SECTION 1915(c) WAIVER FORMAT

1. The State of Indiana requests a Medicaid home and community-based services waiver under the authority of section 1915(c) of the Social Security Act. The administrative authority under which this waiver will be operated is contained in Appendix A.

   This is a request for a model waiver.
   a. x Yes b. _____ No
   If Yes, the State assures that no more than 200 individuals will be served by this waiver at any one time.

   This waiver is requested for a period of (check one):

   a. x 3 years (initial waiver)

   b. _____ 5 years (renewal waiver)

2. This waiver is requested in order to provide home and community-based services to individuals who, but for the provision of such services, would require the following levels (s) of care, the cost of which could be reimbursed under the approved Medicaid State plan:

   a. _____ Nursing facility (NF)

   b. _____ Intermediate care facility for mentally retarded or persons with related conditions (ICF/MR)

   c. x Hospital (inpatient state mental health hospital for individuals at least age 4 under 21 years of age for initial eligibility.) Continuing eligibility to age 22.

   d. _____ NF (served in hospital)

   e. _____ ICF/MR (served in hospital)

3. A waiver of section 1902(a)(10)(B) of the Act is requested to target waiver services to one of the select group(s) of individuals who would be otherwise eligible for waiver

services:

a._____ aged (age 65 and older)

b._____ disabled
c._____ aged and disabled
d._____ mentally retarded
e._____ developmentally disabled

f._____ mentally retarded and developmentally disabled
g.__x__ chronically mentally ill

4. A waiver of section 1902(a)(10)(B) of the Act is also requested to impose the following additional targeting restrictions (specify):

a.__x__ Waiver services are limited to the following age groups (specify):
Children and youth at least 4 years and under age 21 may be eligible to enter the waiver program. Persons age 19 to 20 may meet initial eligibility for the waiver if they have received continual intensive community based services at least 6 months between the ages of 16 and 18 or they are being discharged from a hospital level of care and would not be able to return to the community without such support. Eligibility may continue to age 22.

b.__x__ Waiver services are limited to individuals with the following disease(s) or condition(s) (specify):
Children who are Seriously Emotionally Disturbed (SED) and who meet the hospital Level of Care criteria described in the application.

c. _____Waiver services are limited to individuals who are mentally retarded or developmentally disabled, who reside in general NFs, but who have been shown, as a result of the Pre-Admission Screening and Annual

Resident Review process mandated by P.L. 100-203 to require active treatment at the level of an ICF/MR.

d._____ Other criteria. (Specify):

_____

_____

_____

e._____ Not applicable.

5. Except as specified in item 6 below, an individual must meet the Medicaid eligibility criteria set forth in Appendix C-1 in addition to meeting the targeting criteria in items 2 through 4 of this request.

6. This waiver program includes individuals who are eligible under medically needy groups.

a._____ Yes b.____X___ No

7. A waiver of §1902(a)(10)(C)(i)(III) of the Social Security Act has been requested in order to use institutional income and resource rules for the medically needy.

a._____ Yes b._____ No c.___x___ N/A

8. The State will refuse to offer home and community-based services to any person for whom it can reasonably be expected that the cost of home or community-based services furnished to that individual would exceed the cost of a level of care referred to in item 2 of this request.

a._____ Yes b.___x____ No

9. A waiver of the "statewideness" requirements set forth in section 1902(a)(1) of the Act is requested.

a.___x___ Yes b._____ No

If yes, waiver services will be furnished only to individuals in the following geographic areas or political subdivisions of the State (Specify):

The model waiver would be available only in system of care sites in the following counties: Elkhart; Lake; Knox; Pike; Daviess; Martin; Marion; Randolph; St. Joseph; and Vigo.

10. A waiver of the amount, duration and scope of services requirements contained in section 1902(a)(10)(B) of the Act is requested, in order that services not otherwise available under the approved Medicaid State plan may be provided to individuals served on the waiver.

11. The State requests that the following home and community-based services, as described and defined in Appendix B.1 of this request, be included under this waiver:

a. X Case management **(Wraparound Facilitation)**

b. _____ Homemaker

c. _____ Home health aide services

d. _____ Personal care services

e. X Respite care

f. _____ Adult day health

g. _____ Habilitation
- _____ Residential habilitation
- _____ Day Habilitation
- _____ Prevocational services
- _____ Supported employment services
- _____ Educational services

h. _____ Environmental accessibility adaptations

i. _____ Skilled nursing

j. _____ Transportation

k. _____ Specialized medical equipment and supplies

l._____ Chore services

m._____ Personal Emergency Response Systems

n._____ Companion services

o._____ Private duty nursing

p.__x__ Family training **and Support**

q._____ Attendant care

r._____ Adult Residential Care

_____ Adult foster care

_____ Assisted living

s._____ Extended State plan services (Check all that apply):

_____ Physician services

_____ Home health care services

_____ Physical therapy services

_____ Occupational therapy services

_____ Speech hearing and language services

_____ Prescribed drugs

_____ Other (specify):

_____
_____
_____

t._____ Other services (specify):

_____
_____

u. ___x_____ The following services will be provided to individuals with chronic mental illness:

_____ Day treatment/Partial hospitalization

_____ Psychosocial rehabilitation

_____ Clinic services (whether or not furnished in a facility)

___x_____ Other: **Independent Living Skills**

12. The state assures that adequate standards exist for each provider of services under the waiver. The State further assures that all provider standards will be met.

13. An individual written plan of care will be developed by qualified individuals for each individual under this waiver. This plan of care will describe the medical and other services (regardless of funding source) to be furnished, their frequency, and the type of provider who will furnish each. All services will be furnished pursuant to a written plan of care. The plan of care will be subject to the approval of the Medicaid agency. FFP will not be claimed for waiver services furnished prior to the development of the plan of care. FFP will not be claimed for waiver services, which are not included in the individual written plan of care.

14. Waiver services will not be furnished to individuals who are inpatients of a hospital, NF, or ICF/MR.

15. FFP will not be claimed in expenditures for the cost of room and board, with the following exception(s) (Check all that apply):

a. ___X____ When provided as part of respite care in a facility approved by the State that is not a private residence (hospital, NF, foster home, or community residential facility).

b. _____ Meals furnished as part of a program of adult

day health services.

c. When a live-in personal caregiver (who is unrelated to the individual receiving care) provides approved waiver services, a portion of the rent and food that may be reasonably attributed to the caregiver who resides in the same household with the waiver recipient. FFP for rent and food for a live-in caregiver is not available if the recipient lives in the caregiver's home, or in a residence that is owned or leased by the provider of Medicaid services. An explanation of the method by which room and board costs are computed is included in Appendix G-3.

For purposes of this provision, "board" means 3 meals a day, or any other full nutritional regimen.

16. The Medicaid agency provides the following assurances to HCFA:

a. Necessary safeguards have been taken to protect the health and welfare of persons receiving services under this waiver. Those safeguards include:

1. Adequate standards for all types of providers that furnish services under the waiver (see Appendix B);

2. Assurance that the standards of any State licensure or certification requirements are met for services or for individuals furnishing services that are provided under the waiver (see Appendix B). The State assures that these requirements will be met on the date that the services are furnished; and

3. Assurance that all facilities covered by section 1616(e) of the Social Security Act, in which home and community-based services will be provided, are in compliance with applicable State standards that meet the requirements of 45 CFR Part 1397 for board and care facilities.

b. The agency will provide for an evaluation (and periodic reevaluations, at least annually) of the need for a

level of care indicated in item 2 of this request, when there is a reasonable indication that individuals might need such services in the near future (one month or less), but for the availability of home and community based services. The requirements for such evaluations and reevaluations are detailed in Appendix D.

c. When an individual is determined to be likely to require a level of care indicated in item 2 of this request, and is included in the targeting criteria included in items 3 and 4 of this request, the individual or his or her legal representative will be:

1. Informed of any feasible alternatives under the waiver; and
2. Given the choice of either hospital or home and community based services.

d. The agency will provide an opportunity for a fair hearing, under 42 CFR Part 431, subpart E, to persons who are not given the choice of home or community based services as an alternative to hospital care indicated in item 2 of this request, or who are denied the service(s) of their choice, or the provider(s) of their choice.

e. The average per capita expenditures under the waiver will not exceed 100 percent of the average per capita expenditures for the level(s) of care indicated in item 2 of this request under the State plan that would have been made in that fiscal year had the waiver not been granted.

f. The agency's actual total expenditure for home and community-based and other Medicaid services under the waiver and its claim for FFP in expenditures for the services provided to individuals under the waiver will not, in any year of the waiver period, exceed 100 percent of the amount that would be incurred by the State's Medicaid program for these individuals in the hospital setting(s) indicated in item 2 of this request in the absence of the waiver.

g. Absent the waiver, persons served in the waiver would receive the appropriate type of Medicaid-funded hospital care that they require, as indicated in item 2 of this request.

h. The agency will provide HCFA annually with information on the impact of the waiver on the type, amount and cost of services provided under the State plan and on the health and welfare of the persons served on the waiver. The information will be consistent with a data collection plan designed by HCFA.

i. The agency will assure financial accountability for funds expended for home and community-based services, provide for an independent audit of its waiver program (except as HCFA may otherwise specify for particular waivers), and it will maintain and make available to HHS, the Comptroller General, or other designees, appropriate financial records documenting the cost of services provided under the waiver, including reports of any independent audits conducted.

The State conducts a single audit in conformance with the Single Audit Act of 1984, P.L. 98-502.
a. x Yes b. _____ No

17. The State will provide for an independent assessment of its waiver that evaluates the quality of care provided, access to care, and cost-neutrality The results of the assessment will be submitted to HCFA at least 90 days prior to the expiration of the approved waiver period and cover the first 24 months (new waivers) or 48 months (renewal waivers) of the waiver.
a. _____ Yes b. X No

18. The State assures that it will have in place a formal system by which it ensures the health and welfare of the individuals served on the waiver, through monitoring of the quality control procedures described in this waiver document (including Appendices). Monitoring will ensure that all provider standards and health and welfare assurances are continuously met, and that plans of care are periodically reviewed to ensure that the services furnished are consistent with the identified needs of the individuals. Through these procedures, the State will ensure the quality of services furnished under the waiver and the State plan to waiver persons served on the waiver. The State further assures that all problems identified by this monitoring will be addressed in an appropriate and timely manner, consistent

with the severity and nature of the deficiencies.

18. An effective date of January 1, 2004 is requested.

19. The State contact person for this request is Beth Fetters, who can be reached by telephone at (317) 232-7939 .

20. This document, together with Appendices A through G, and all attachments, constitutes the State's request for a home and community-based services waiver under section 1915(c) of the Social Security Act. The State affirms that it will abide by all terms and conditions set forth in the waiver (including Appendices and attachments), and certifies that any modifications to the waiver request will be submitted in writing by the State Medicaid agency. Upon approval by HCFA, this waiver request will serve as the State's authority to provide home and community services to the target group under its Medicaid plan. Any proposed changes to the approved waiver will be formally requested by the State in the form of waiver amendments.

The State assures that all material referenced in this waiver application (including standards, licensure and certification requirements) will be kept on file at the Medicaid agency.

Signature: _____
Print Name: Melanie Bella
Title: Assistant Secretary, Office of Medicaid Policy and Planning
Date: _____

APPENDIX A - ADMINISTRATION

LINE OF AUTHORITY FOR WAIVER OPERATION

CHECK ONE:

_____ The waiver will be operated directly by the Medical Assistance Unit of the Medicaid agency.

_____ The waiver will be operated by _____, a separate agency of the State, under the supervision of the Medicaid agency. The Medicaid agency exercises administrative discretion in the administration and supervision of the waiver and issues policies, rules and regulations related to the waiver. A copy of the interagency agreement setting forth the authority and arrangements for this policy is on file at the Medicaid agency.

x The waiver will be operated by The Indiana Division of Mental Health and Addiction, a separate division within the Single State agency. The Medicaid agency exercises administrative discretion in the administration and supervision of the waiver and issues policies, rules and regulations related to the waiver. A copy of the interagency agreement setting forth the authority and arrangements for this policy is on file at the Medicaid agency.

APPENDIX B - SERVICES AND STANDARDS

APPENDIX B-1: DEFINITION OF SERVICES

The State requests that the following home and community-based services, as described and defined herein, be included under this waiver. Provider qualifications/standards for each service are set forth in Appendix B-2. The State of Indiana has developed definitions for each service covered under the waiver.

a. x Case Management

_____ Services which will assist individuals who receive waiver services in gaining access to needed waiver and other State plan services, as well as needed medical, social, educational and other services, regardless of the funding source for the services to which access is gained.

Case managers shall be responsible for ongoing monitoring of the provision of services included in the individual's plan of care.

1. x Yes 2. _____ No

Case managers shall initiate and oversee the process of assessment and reassessment of the individual's level of care and the review of plans of care at such intervals as are specified in Appendices C & D of this request.

1. x Yes 2. _____ No

x Other Service Definition (Specify):
Wraparound Facilitation: This service will involve assessment of the child's and family's/caretaker's strengths and needs to

determine overall needs of the community based waiver and non-waiver services. This service will produce an individualized community-based plan to access services and to be part of informal community resources and develop relationships to help the child succeed in the community. The community-based plan identifies specific plan goals, objectives, responsibilities, timeliness, outcomes, performance measures, and costs. This process will emphasize building collaboration and coordination among family, caretakers, service providers, educators, and community resources. Facilitation will promote flexibility to ensure that appropriate and effective services are delivered to the child and family/caretaker. Facilitators will be complete specialized training and work with the child, family and others to ensure proper facilitation in appropriate use of resources. The facilitator will monitor processes that include evaluation of current services, child and family/caretaker needs, service outcomes at various points in time the child is enrolled in the waiver.

b. Homemaker:

Services consisting of general household activities (meal preparation and routine household care) provided by a trained homemaker, when the individual regularly responsible for these activities is temporarily absent or unable to manage the home and care for him or herself or others in the home. Homemakers shall meet such standards of education and training as are established by the State for the provision of these activities.

_____ Other Service Definition (Specify):

_____

_____

c._____ Home Health Aide services:

_____ Services defined in 42 CFR 440.70, with the exception that limitations on the amount, duration and scope of such services imposed by the State's approved Medicaid plan shall not be applicable. The amount, duration and scope of these services shall instead be in accordance with the estimates given in Appendix G of this waiver request. Services provided under the waiver shall be in addition to any available under the approved State plan.

_____ Other Service Definition (Specify):

_____
_____
_____
_____
_____

d. Personal care services:

Assistance with eating, bathing, dressing, personal hygiene, activities of daily living. These services may include assistance with preparation of meals, but does not include the cost of the meals themselves. when specified in the plan of care, this service may also include such housekeeping chores as bedmaking, dusting and vacuuming, which are incidental to the care furnished, or which are essential to the health and welfare of the individual, rather than the individual's family. Personal care providers must meet State standards for this service.

1. Services provided by family members (Check one):

_____ Payment will not be made for personal care services furnished by a member of the individual's family.

_____ Personal care providers may be members of the individual's family. Payment will not be made for services furnished to a minor by the child's parent (or step-parent), or to an individual by that person's spouse.

Justification attached. (Check one):

_____ Family members who provide personal care services must meet the same standards as providers who are unrelated to the individual.

_____ Standards for family members providing personal care services differ from those for other providers of this service. The different standards are indicated in Appendix B-2.

2. Supervision of personal care providers will be furnished by (Check all that apply):

_____ A registered nurse, licensed to practice nursing in the

State.

_____ A licensed practical or vocational nurse, under the supervision of a registered nurse, as provided under State law.

_____ Case managers

_____ Other (Specify):

_____
_____
_____
_____

3. Frequency or intensity of supervision (Check one):

_____ As indicated in the plan of care

_____ Other (Specify):

_____
_____
_____

4. Relationship to State plan services (Check one):

Personal care services are not provided under the approved State plan.

_____ Personal care services are included in the State plan, but with limitations. The waivered service will serve as an extension of the State plan service, in accordance with documentation provided in

Appendix G of this waiver request.

_____ Personal care services under the State plan differ in service definition or provider type from the services to be offered under the waiver.

_____ Other service definition (Specify):

_____

_____

_____

_____

e. x Respite care:

_____ Services provided to individuals unable to care for themselves; furnished on a short-term basis because of the absence or need for relief of those persons normally providing the care.

x Other service definition (Specify):
Respite provides short term and temporary direct care and supervision for youth. The primary purpose is relief to families/caretakers of a child with a severe emotional disturbance. Respite may be scheduled or provided in a crisis situation. The service is designed to help meet needs of primary caretakers as well as children. These activities include aid in the home, getting a child to school or program and aid after school, at night, and/or any combination of the above. Respite care can be an in-home service, or provided in other community settings. A maximum of 840 hours a year will be allowed. The child and family must be participating in other intensive treatment and waiver services to qualify for

respite.

FFP will not be claimed for the cost of room and board except when provided as part of respite care furnished in a facility approved by the State that is not a private residence.

Respite care will be provided in the following location(s) (Check all that apply):

___x___ Individual's home or place of residence

___x___ Foster home

_____ Medicaid certified Hospital

_____ Medicaid certified NF

_____ Medicaid certified ICF/MR

___x___ Group home

_____ Licensed respite care facility

___x___ Other community care residential facility approved by the State that it's not a private residence (Specify type):
Emergency Shelter Care
_____
_____

_____ Other service definition (Specify):_____
_____
_____
_____

f._____ Adult day health:

_____ Services furnished 4 or more hours per day on a regularly scheduled basis, for one or more days per week, in an outpatient setting, encompassing both health and social services needed to ensure the optimal functioning of the individual. Meals provided as part of these services shall not constitute a "full nutritional regimen" (3 meals per day).Physical, occupational and speech therapies indicated in the individual's plan of care will be furnished as component parts of this service.

Transportation between the individual's place of residence and the adult day health center will be provided as a component part of adult day health services. The cost of this transportation is included in the rate paid to providers of adult day health services. (Check one):

1._____Yes 2._____No

_____ Other service definition (Specify):_____
_____
_____
_____

Qualifications of the providers of adult day health services are contained in Appendix B-2.

g._____ Habilitation:

_____ Services designed to assist individuals in acquiring, retaining and improving the self-help, socialization and adaptive skills necessary to reside successfully in home and community-based settings. This service includes:

_____ Residential habilitation: assistance with acquisition,

retention, or improvement in skills related to activities of daily living, such as personal grooming and cleanliness, bed making and household chores, eating and the preparation of food, and the social and adaptive skills necessary to enable the individual to reside in a non hospital setting. Payments for residential habilitation are not made for room and board, the cost of facility maintenance upkeep and improvement, other than such costs for modifications or adaptations to a facility required to assure the health and safety of residents, or to meet the requirements of the applicable life safety code. Payment for residential habilitation does not include payments made, directly or indirectly, to members of the individual's immediate family. Payments will not be made for the routine care and supervision which would be expected to be provided by a family or group home provider, or for activities or supervision for which a payment is made by a source other than Medicaid. Documentation which shows that Medicaid payment does not cover these components is attached to Appendix G.

_____Day habilitation: assistance with acquisition, retention, or improvement in self-help, socialization and adaptive skills which takes place in a non-residential setting, separate from the home or facility in which the individual resides. Services shall normally be furnished 4 or more

hours per day on a regularly scheduled basis, for 1 or more days per week unless provided as an adjunct to other day activities included in an individual's plan of care.
Day habilitation services shall focus on enabling the individual to attain or maintain his or her maximum functional level and shall be coordinated with any physical, occupational, or speech therapies listed in the plan of care. In addition, day habilitation services may serve to reinforce skills or lessons taught in school, therapy or other settings.

_____ Prevocational services not available under a program funded under section 110 of the Rehabilitation Act of 1973 or section 602(16) and (17) of the Individuals with Disabilities Education Act (20 U.S.C. 1401(16 and 17)). Services are aimed at preparing an individual for paid or unpaid employment, but are not job-task oriented. Services include teaching such concepts as compliance, attendance, task completion, problem solving and safety. Prevocational services are provided to persons not expected to be able to join the general work force or participate in a transitional sheltered workshop within one year (excluding supported employment programs). Prevocational services are available only to individuals who have previously been discharged from a SNF, ICF, NF or ICF/MR.

Check one:

_____ Individuals will not be compensated for prevocational services.

_____ When compensated, individuals are paid at less than 50 percent of the minimum wage.

Activities included in this service are not primarily directed at teaching specific job skills, but at underlying habilitative goals, such as attention span and motor skills. All prevocational services will be reflected in the individual's plan of care as directed to habilitative, rather than explicit employment objectives.

Documentation will be maintained in the file of each individual receiving this service that:

1. The service is not otherwise available under a program funded under the Rehabilitation Act of 1973, or P.L. 94-142; and

2. The individual has been deinstitutionalized from a SNF, ICF, NF, or ICF/MR at some prior period.

_____ Educational services, which consist of special education and related services as defined in sections

(15) and (17) of the Individuals with Disabilities Education Act, to the extent to which they are not available under a program funded by IDEA. Documentation will be maintained in the file of each individual receiving this service that:

1. The service is not otherwise available under a program funded under the Rehabilitation Act of 1973, or P.L. 94-142; and

2. The individual has been deinstitutionalized from a SNF, ICF, NF, or ICF/MR at some prior period.

_____ Supported employment services, which consist of paid employment for persons for whom competitive employment at or above the minimum wage is unlikely, and who, because of their disabilities, need intensive ongoing support to perform in a work setting. Supported employment is conducted in a variety of settings, particularly work sites in which persons without disabilities are employed. supported employment includes activities needed to sustain paid work by individuals receiving waiver services, including supervision and training. When supported employment services are provided at a work site in which persons without disabilities are employed, payment will be made only for the adaptations, supervision and training required by individuals receiving waiver

services as a result of their disabilities, and will not include payment for the supervisory activities rendered as a normal part of the business setting.

Supported employment services furnished under the waiver are not available under a program funded by either the Rehabilitation Act of 1973 or P.L. 94-142. Documentation will be maintained in the file of each individual receiving this service that:

1. The service is not otherwise available under a program funded under the Rehabilitation Act of 1973, or P.L. 94-142; and

2. The individual has been deinstitutionalized from a SNF, ICF, NF, or ICF/MR at some prior period.

FFP will not be claimed for incentive payments, subsidies, or unrelated vocational training expenses such as the following:

1. Incentive payments made to an employer to encourage or subsidize the employer's participation in a supported employment program;

2. Payments that are passed through to users of supported employment programs; or

3. Payments for vocational training that is not directly

related to an individual's supported employment program.

Transportation will be provided between the individual's place of residence and the site of the habilitation services, or between habilitation sites (in cases where the individual receives habilitation services in more than one place) as a component part of habilitation services. The cost of this transportation is included in the rate paid to providers of the appropriate type of habilitation services.

1._____Yes 2._____No

_____ Other service definition (Specify):

The State requests the authority to provide the following additional services, not specified in the statute. The State assures that each service is cost-effective and necessary to prevent hospitalization. The cost neutrality of each service is demonstrated in Appendix G. Qualifications of providers are found in Appendix B-2.

h._____ Environmental accessibility adaptations:

_____ Those physical adaptations to the home, required by the individual's plan of care, which are necessary to ensure the health, welfare and safety of the individual, or which enable the individual to function with greater independence in the home, and without which, the individual would require institutionalization. Such adaptations may include the installation of ramps and grab-bars, widening of doorways, modification of bathroom facilities, or installation of specialized electric and plumbing systems

which are necessary to accommodate the medical equipment and supplies which are necessary for the welfare of the individual. Excluded are those adaptations or improvements to the home which are of general utility, and are not of direct medical or remedial benefit to the individual, such as carpeting, roof repair, central air conditioning, etc. Adaptations which add to the total square footage of the home are excluded from this benefit. All services shall be provided in accordance with applicable State or local building codes.

_____ Other service definition (Specify):

_____

_____

_____

_____

i._____ Skilled nursing:

_____ Services listed in the plan of care which are within the scope of the State's Nurse Practice Act and are provided by a registered professional nurse, or licensed practical or vocational nurse under the supervision of a registered nurse, licensed to practice in the State.

_____ Other service definition (Specify):

j._____ Transportation:

_____ Service offered in order to enable individuals served on the waiver to gain access to waiver and other community

services, activities and resources, specified by the plan of care. This service is offered in addition to medical transportation required under 42 CFR 431.53 and transportation services under the State plan, defined at 42 CFR 440.170(a) (if applicable), and shall not replace them. Transportation services under the waiver shall be offered in accordance with the individual's plan of care. Whenever possible, family, neighbors, friends, or community agencies which can provide this service without charge will be utilized.

_____ Other service definition (Specify):

_____

_____

_____

k._____ Specialized Medical Equipment and Supplies:

_____ Specialized medical equipment and supplies to include devices, controls, or appliances, specified in the plan of care, which enable individuals to increase their abilities to perform activities of daily living, or to perceive, control, or communicate with he environment in which they live.

This service also includes items necessary for life support, ancillary supplies and equipment necessary to the proper functioning of such items, and durable and non-durable medical equipment not available under the Medicaid State plan. Items reimbursed with waiver funds shall be in addition to any medical equipment and supplies furnished under the State plan and shall exclude those items which are not of direct medical or remedial benefit to the individual. All

items shall meet applicable standards of manufacture, design and installation.

_____ Other service definition (Specify):

_____
_____
_____
_____

1. _____ Chore services:

Services needed to maintain the home in a clean, sanitary and safe environment. This service includes heavy household chores such as washing floors, windows and walls, tacking down loose rugs and tiles, moving heavy items of furniture in order to provide safe access and egress. These services will be provided only in cases where neither the individual, nor anyone else in the household, is capable of performing or financially providing for them, and where no other relative, caregiver, landlord, community/volunteer agency, or third party payor is capable of or responsible for their provision. In the case of rental property, the responsibility of the landlord, pursuant to the lease agreement, will be examined prior to any authorization of service.

_____ Other service definition (Specify):

_____
_____
_____
_____
_____
_____

m._____ Personal Emergency Response Systems (PERS)

_____ PERS is an electronic device which enables certain individuals at high risk of institutionalization to secure help in an

emergency. The individual may also wear a portable "help" button to allow for mobility. The system is connected to the person's phone and programmed to signal a response center once a "help" button is activated. The response center is staffed by trained professionals, as specified in Appendix B-2. PERS services are limited to those individuals who live alone, or who are alone for significant parts of the day, and have no regular caregiver for extended periods of time, and who would otherwise require extensive routine supervision.

_____ Other service definition (Specify):

_____
_____
_____
_____

n. _____ Adult companion services:

Non-medical care, supervision and socialization, provided to a functionally impaired adult. Companions may assist or supervise the individual with such tasks as meal preparation, laundry and shopping, but do not perform these activities as discrete services. The provision of companion services does not entail hands-on nursing care. Providers may also perform light housekeeping tasks which are incidental to the care and supervision of the individual. This service is provided in accordance with a therapeutic goal in the plan of care, and is not purely diversional in nature.

_____ Other service definition (Specify):

_____
_____
_____
_____

o._____ Private duty nursing:

_____ Individual and continuous care (in contrast to part time or intermittent care) provided by licensed nurses within the scope of State law. These services are provided to an individual at home.

_____ Other service definition (Specify):

_____

_____

p. x **Family training:**

Training and counseling services for the families of individuals served on this waiver. For purposes of this service, "family" is defined as the persons who live with or provide care to a person served on the waiver, and may include a parent, spouse, children, relatives, foster family, or in-laws. "Family" does not include individuals who are employed to care for the consumer. Training includes instruction about treatment regimens and use of equipment specified in the plan of care, and shall include updates as necessary to safely maintain the individual at home. All family training must be included in the individual's written plan of care.

x Other service definition (Specify: **Family Support and Training)**

In order to encourage and maintain the family to care for the child in the home and community, services which benefit the eligible child in their home and community will include assisting and coaching the family to increase their knowledge and awareness of the child's needs, the process of interpreting choices offered by service providers, explanations and interpretations of policies, procedures, and regulations that impact the child living in the community, and behavioral management

training. For purpose of this service, *family* is defined as the persons who live with or provide care to a person served on this waiver, and may include a parent, spouse, children, relatives, foster family, or in-laws. *Family* does not include individuals employed to care for consumer. Training will include involving families in developing plans of care, education regarding child's needs and resources, behavioral management training, monitoring, and evaluation.

q._____ Attendant care services:

_____ Hands-on care, of both a supportive and health-related nature, specific to the needs of a medically stable, physically handicapped individual. Supportive services are those which substitute for the absence, loss, diminution, or impairment of a physical or cognitive function. this service may include skilled or nursing care to the extent permitted by State law. Housekeeping activities which are incidental to the performance of care may also be furnished as part of this activity.

Supervision (Check all that apply):

_____ Supervision will be provided by a Registered Nurse, licensed to practice in the State. The frequency and intensity of supervision will be specified in the individual's written plan of care.

_____ Supervision may be furnished directly by the individual, when the person has been trained to perform this function, and when the safety and efficacy of consumer-provided supervision has been certified in writing by a

registered nurse or otherwise as provided in State law. This certification must be based on direct observation of the consumer and the specific attendant care provider, during the actual provision of care. Documentation of this certification will be maintained in the consumer's individual plan of care.

_____ Other supervisory arrangements (Specify):

_____
_____
_____

_____ Other service definition (Specify):

_____
_____
_____
_____

r._____ Adult Residential Care (Check all that apply):

_____ Adult foster care: Personal care and services, homemaker, chore, attendant care and companion services medication oversight (to the extent permitted under State law) provided in a licensed (where applicable) private home by a principal care provider who lives in the home. Adult foster care is furnished to adults who receive these services in conjunction with residing in the home. the total number of individuals (including persons served in the waiver) living in the home, who are unrelated to the principal care provider, cannot exceed____). Separate payment will not be made for homemaker or chore services furnished to an individual receiving adult foster care services, since these services are integral to and inherent in the provision of adult

foster care services.

_____ Assisted living: Personal care and services, homemaker, chore, attendant care, companion services, medication oversight (to the extent permitted under State law), therapeutic social and recreational programming, provided in a home-like environment in a licensed (where applicable) community care facility, in conjunction with residing in the facility. This service includes 24-hour on-site response staff to meet scheduled or unpredictable needs in a way that promotes maximum dignity and independence, and to provide supervision, safety and security. Other individuals or agencies may also furnish care directly, or under arrangement with the community care facility, but the care provided by these other entities supplements that provided by the community care facility and does not supplant it.

Personalized care is furnished to individuals who reside in their own living units (which may include dually occupied units when both occupants consent to the arrangement) which may or may not include kitchenette and/or living rooms and which contain bedrooms and toilet facilities. The consumer has a right to privacy. Living units may be locked at the discretion of the consumer, except when a physician or mental health professional has certified in writing that the consumer is sufficiently cognitively impaired as to be a danger to self or others if given the opportunity to lock the door. (This requirement does not apply where it conflicts with fire code.) Each living unit is separate and distinct from each other. The facility must have a central dining room, living room or parlor, and common activity center(s) (which may also serve as living rooms or dining rooms). The consumer retains the right to assume risk, tempered only by

the individual's ability to assume responsibility for that risk. Care must be furnished in a way which fosters the independence of each consumer to facilitate aging in place. Routines of care provision and service delivery must be consumer-driven to the maximum extent possible, and treat each person with dignity and respect.

Assisted living services may also include (Check all that apply):

_____ Home health care

_____ Physical therapy

_____ Occupational therapy

_____ Speech therapy

_____ Medication administration

_____ Intermittent skilled nursing services

_____ Transportation specified in the plan of care

_____ Periodic nursing evaluations

_____ Other (Specify)

_____

_____

However, nursing and skilled therapy services (except periodic nursing evaluations if specified above) are incidental, rather than integral to the provision of assisted living services. Payment will not be made for 24-hour skilled care or supervision. FFP is not available in the cost of room and board furnished in conjunction with residing in an

assisted living facility.

_____ Other service definition (Specify):

_____

_____

_____

Payments for adult residential care services are not made for room and board, items of comfort or convenience, or the costs of facility maintenance, upkeep and improvement. Payment for adult residential care services does not include payments made, directly or indirectly, to members of the consumer's immediate family. The methodology by which payments are calculated and made is described in Appendix G.

s._____ Other waiver services which are cost-effective and necessary to prevent institutionalization (Specify):

_____

_____

t._____ Extended State plan services:

The following services, available through the approved State plan, will be provided, except that the limitations on amount, duration and scope specified in the plan will not apply. Services will be as defined and described in the approved State plan. The provider qualifications listed in the plan will apply, and are hereby incorporated into this waiver request by reference. These services will be provided under the State plan until the plan limitations have been reached. Documentation of the extent of services and cost-effectiveness are demonstrated in Appendix G. (Check all that apply):

_____ Physician services

_____ Home health care services

_____ Physical therapy services

_____ Occupational therapy services

_____ Speech, hearing and language services

_____ Prescribed drugs

_____ Other State plan services (Specify):

_____

_____

_____

_____

u. X Services for individuals with chronic mental illness, consisting of (Check one):

_____ Day treatment or other partial hospitalization services (Check one):

____ Services that are necessary for the diagnosis or treatment of the individual's mental illness. These services consist of the following elements:

a. individual and group therapy with physicians or psychologists (or other mental health professionals to the extent authorized under State law),

b. occupational therapy, requiring the skills of a qualified occupational therapist,

c. services of social workers, trained psychiatric nurses, and other staff trained to work with individuals with psychiatric illness,

d. drugs and biologicals furnished for therapeutic purposes,

e. individual activity therapies that are not primarily recreational or diversionary,

f. family counseling (the primary purpose of which is treatment of the individual's condition),

g. training and education of the individual (to the extent that training and educational activities are closely and clearly related to the individual's care and treatment), and

h. diagnostic services.

Meals and transportation are excluded from reimbursement under this service. The purpose of this service is to maintain the individual's condition and functional level and to prevent relapse or hospitalization.

__x__ Other service definition (Specify):
Independent Living Skills: Services designed to assist children and adolescents in acquiring, retaining, and improving
The self-help, socialization and adaptive skills necessary to reside successfully in home and community-based settings.
Activities are designed to foster eventual or intended ability to live independently within a community

setting. These activities are intended to enhance the components related to family, school, work , and assistance with development, acquisition, retention, or improvement of skills necessary to enable the individual to reside in a non-hospital setting. This service includes budgeting, shopping, and working, engaging in recreational activities with peers, peer to peer support and appropriate work skills to remain in the community. This service will be provided by a trained worker who will provide modeling, direction, and support to children and adolescents.

____ Psychosocial rehabilitation services (Check one):

____ Medical or remedial services recommended by a physician or other licensed practitioner under State law, for the maximum reduction of physical or mental disability and the restoration of maximum functional level. Specific services include the following:

a. restoration and maintenance of daily living skills (grooming, personal hygiene, cooking, nutrition, health and mental health education, medication management, money management and maintenance of the living environment);

b. social skills training in appropriate use of community services;

c. development of appropriate personal support networks, therapeutic recreational services (which are focused on therapeutic intervention, rather than diversion); and

d. telephone monitoring and counseling services.

The following are specifically excluded from Medicaid payment for psychosocial rehabilitation services:

a. vocational services,

b. prevocational services,

c. supported employment services, and

d. room and board.

_____ Other service definition (Specify):

_____ Clinic services (whether or not furnished in a facility) are services defined in 42 CFR 440.90.

Check one:

_____ This service is furnished only on the premises of a clinic.

_____ Clinic services provided under this waiver may be furnished outside the clinic facility. Services may be furnished in the following locations (Specify):

APPENDIX B-2
PROVIDER QUALIFICATIONS
LICENSURE AND CERTIFICATION CHART

The following chart indicates the requirements for the provision of each service under the waiver. Licensure, Regulation, and State Administrative Code are referenced by citation. Standards not addressed under uniform State citation are attached.

SERVICE	PROVIDER	LICENSE	CERTIFICATION	OTHER STANDARD
Wraparound Facilitation	Providers of community mental health services meeting the certification requirements.	NA	Accreditation by one of the DMHA approved accreditation organizations, provision of a continuum of care consistent with 440 IAC 9-1-6, 440 IAC 9-2-2 - 440 IAC 9-2-13 (which includes 24-hour/day crisis intervention) and participation in a system of care including both a governing coalition and service delivery endorsing the values and principles of a system of care. Provider entities will maintain documentation that individual Wraparound Facilitators meet "other standards" and training requirements as described in the provider qualification chart. Wraparound facilitation providers must enroll all waiver children in the Community Service Data System (CSDS).	Wraparound Facilitators must complete DMHA required training. A bachelor's degree in human services or a related field; or other approved work/personal experience in providing direct services or linking of services for children with severe emotional disturbance, in addition to training as a children's mental health case manager as required by 440 IAC 9-2-10 (prefer experience as child case manager). Wraparound facilitators must have a criminal history screen, a screen with state and local Child Protection Agency registries, and drug screen. They must be supervised by an individual who meets criteria as a qualified mental health professional (QMHP) (405 IAC 5-21-1(c)), who has completed DMHA required training. Must be affiliated with system of care approved by DMHA.
Family Support and Training	Agencies and individuals meeting the certification requirements.	NA	Providers must be certified by DMHA. Non-agency providers must provide	Family Support Workers must have a high school diploma or equivalent (with preference given to individuals who have experience

			documentation that they meet all standards listed under "other standards" and that they have arranged for clinical supervision through a DMHA approved agency. All entities will maintain documentation that individual workers meet "other standards" and training requirements as described in the provider qualification chart.	working with children and families); at least 21 years old; completion of DMHA approved training program. Pass criminal history requirements as described in the foster parents licensure standards (Child Welfare Manual 609.21 & 609.22, required by IC 12-17.4-3-4-3), screen with state and local Child Protection Agency registries, and drug screen. Individuals will participate in child-family team meetings. Supervised by an individual who meets criteria for a QMHP.
Independent Living Skills	Agencies and individuals meeting the certification requirements		Agencies must be certified by DMHA. Non-agency providers must provide documentation that they meet all standards listed under "other standards" and that they have arranged for clinical supervision through a DMHA approved agency. Entities will maintain documentation that individual workers meet "other standards" and training requirements as described in the provider qualification chart.	Worker qualifications: Must be at least 21 years old; minimum of two years working with youth (preference given to experience with youth with SED); high school diploma or equivalent; completion of approved training in skill area(s) needed by the youth. Meet criminal history requirements as described in the foster parents licensure standards (Child Welfare Manual 609.21 & 609.22, required by IC 12-17.4-3-4-3)), screen with state and local Child Protection Agency registries, and drug screen. Worker will participate in child-family meetings. Worker must be supervised by a QMHP as defined by 405 IAC 5-21-1(c).
Respite care	Agencies and individuals meeting the licensure and/or certification requirements	Individual foster homes must provide documentation of licensure. Agencies utilizing foster homes and/or emergency shelter homes must maintain documentation of licensure of these entities.	Entities not subject to licensure must be certified by DMHA. Non-agency providers not subject to licensure must provide documentation that they meet all standards listed under "other standards" and that they have arranged for clinical	Worker qualifications: Must be at least 21 years of age; high school diploma or equivalent. Working or personal experience with children (preference given to those who have worked with children with SED); completion of DMHA approved training program; must be supervised by an individual who meets the criteria for a QMHP. Meet criminal history requirements as described in the foster parents licensure

		IC 12-17.4 - foster homes and emergency shelters 470 IAC 3-12 Emergency Shelter Care (Rule 12) 470 IAC 3-15 Emergency Shelter Care Group Homes (Rule 15). Child Welfare Manual, Section 6 603.3 Special Needs Foster Home or 603.4 Therapeutic Foster Home	supervision through a DMHA approved agency. Entities will maintain documentation that individual workers meet "other standards" and training requirements as described in the provider qualification chart.	standards (Child Welfare Manual 609.21 & 609.22, required by IC 12-17.4-3-4-3), screen with state and local Child Protection Agency registries, and drug screen. Individual/provider agency would participate in child-family team meetings.

B. ASSURANCE THAT REQUIREMENTS ARE MET

The State assures that the standards of any State licensure or certification requirements are met for services or for individuals furnishing services provided under the waiver.

C. PROVIDER REQUIREMENTS APPLICABLE TO EACH SERVICE

For each service for which standards other than, or in addition to State licensure or certification must be met by providers, the applicable educational, professional, or other standards for service provision or for service providers are attached to this Appendix, tabbed and labeled with the name of the service(s) to which they apply.

When the qualifications of providers are set forth in State or Federal law or regulation, it is not necessary to provide copies of the applicable documents. However, the documents must be on file with the State Medicaid agency, and the licensure and certification chart at the head of this Appendix must contain the precise citation indicating where the standards may be found.

D. FREEDOM OF CHOICE

The State assures that each individual found eligible for the waiver will be given free choice of all qualified providers of each service included in his or her written plan of care.

APPENDIX B-3
KEYS AMENDMENT STANDARDS FOR BOARD AND CARE FACILITIES

KEYS AMENDMENT ASSURANCE:

The State assures that all facilities covered by section 1616(e) of the Social Security Act, in which home and community-based services will be provided are in compliance with applicable State standards that meet the requirements of 45 CFR Part 1397 for board and care facilities.

APPLICABILITY OF KEYS AMENDMENT STANDARDS:

Check one:

__X__ Home and community-base services will not be provided in facilities covered by section 1616(e) of the Social Security Act. Therefore, no standards are provided.

_____ A copy of the standards applicable to each type of facility identified above is maintained by the Medicaid agency.

SECTION 1915(c) WAIVER FORMAT

APPENDIX C-Eligibility and Post-Eligibility

Appendix C-1--Eligibility

MEDICAID ELIGIBILITY GROUPS SERVED

Individuals receiving services under this waiver are eligible under the following eligibility group(s) in your State plan. The State will apply all applicable FFP limits under the plan. **(Check all that apply.)**

1. x Low income families with children as described in section 1931 of the Social Security Act.

2. _____ SSI recipients (SSI Criteria States and 1634 States).

3. X Aged, blind or disabled in 209(b) States who are eligible under § 435.121 (aged, blind or disabled who meet requirements that are more restrictive than those of the SSI program).

4. ____ Optional State supplement recipients

5. ____ Optional categorically needy aged and disabled who have income at (Check one):

   a. ____ 100% of the Federal poverty level (FPL)

   b. ____% Percent of FPL which is lower than 100%.

6. X The special home and community-based waiver group under 42 CFR 435.217 (Individuals who would be eligible for Medicaid if they were in a hospital who have been determined to need home and community-based services in order to remain in the community, and who are covered under the terms of this waiver).

Spousal impoverishment rules are used in determining eligibility for the special home and community-based waiver group at 42 CFR 435.217.

___ A. Yes ___X__ B. No

Check one:

a.___ The waiver covers all individuals who would be eligible for Medicaid if they were in a medical institution and who need home and community-based services in order to remain in the community; or

b. X Only the following groups of individuals who would be eligible for Medicaid if they were in a medical institution and who need home and community-based services in order to remain in the community are included in this waiver: (check all that apply):

(1) X A special income level equal to:

X 300% of the SSI Federal benefit (FBR)

___% of FBR, which is lower than 300% (42 CFR 435.236)

$___ which is lower than 300%

(2) X Aged, blind and disabled who meet requirements that are more restrictive than those of the SSI program. (42 CFR 435.121)

(3)___ Medically needy without spenddown in States which also provide Medicaid to recipients of SSI. (42 CFR 435.320, 435.322, and 435,324.)

(4)___ Medically needy without spenddown in 209(b) States.
(42 CFR 435.330)

(5)___ Aged and disabled who have income at:

a.____ 100% of the FPL

b.___% which is lower than 100%.

(6)___ Other (Include statutory reference only to reflect additional groups included under the State plan.)

7. ___ Medically needy (42 CFR 435.320, 435.322, 435.324 and 435.330)

8. x Other (Include only statutory reference to reflect additional groups under your plan that you wish to include under this waiver.)
The categories specified in the Social Security Act as added by TWWIIA:
Section1902(a)(10)(A)(ii)(XV)
Section1902(a)(10)(A)(ii)(XVI)

POST ELIGIBILITY

REGULAR POST ELIGIBILITY SSI State

1.____ **SSI State.** The State is using the post-eligibility rules at 42 CFR 435.726. Payments for home and community-based waiver services are reduced by the amount remaining after deduction the following amounts from the waiver recipient's income.

A. **§ 435.726**--States which **do not use more restrictive** eligibility requirements than SSI.

a. Allowances for the needs of the

1. individual: (Check one):

A.___ The following standard included under the State plan (check one):

(1)___ SSI

(2)___ Medically needy

(3)___ The special income level for the institutionalized

(4)___ The following percent of the Federal poverty level):___%

(5)___ Other (specify):

_____

B.___ The following dollar amount:
$_____*

* If this amount changes, this item will be revised.

C.___ The following formula is used to determine the needs allowance:

Note: If the amount protected for waiver recipients in item 1. is **equal to, or greater than** the maximum amount of income a waiver recipient may have and be

eligible under 42 CFR 435.217, **enter NA in items 2. and 3**. following.

2. spouse only (check one):

A.___ SSI standard

B.___ Optional State supplement standard

C.___ Medically needy income standard

D.___ The following dollar amount:
$_____*

* If this amount changes, this item will be revised.

E.___ The following percentage of the following standard that is not greater than the standards above: ____% of ____standard.

F.___ The amount is determined using the following formula:

G.___ Not applicable (N/A)

3. Family (check one):

A.___ AFDC need standard

B.___ Medically needy income standard

The amount specified below cannot exceed the higher of the need standard for a family of the same size used to determine eligibility under the State's approved AFDC plan or the medically income standard established under 435.811 for a family of the same size.

C.___ The following dollar amount:
$____*

*If this amount changes, this item will be revised.

D.___ The following percentage of the following standard that is not greater than the standards above: %___ of ____ standard.

E.___ The amount is determined using the following formula:

F.____ Other

G.___ Not applicable (N/A)

b. Medical and remedial care expenses specified in 42 CFR 435.726.

POST-ELIGIBILITY

REGULAR POST ELIGIBILITY 209(b) State

1.(b) X **209(b) State, a State that is using more restrictive eligibility requirements than SSI**. The State is using the post-eligibility rules at 42 435.735. Payments for home and community-based waiver services are reduced by the amount remaining after deduction the following amounts from the waiver recipient's income.

B. **42 CFR 435.735**--States **using more restrictive** requirements than SSI.

(a) Allowances for the needs of the

1. individual: (check one):

A. X The following standard included under the State plan (check one):

(1) ___ SSI

(2) ___ Medically needy

(3) ___ The special income level for the institutionalized

(4) ___ The following percentage of the Federal poverty level: ____ %

(5) X Other (specify):
The amount specified in the Medicaid State Plan , Supplement 7 to Attachment 2.6-A, page 1 for an unmarried applicant/recipient.

B. ___ The following dollar amount:
$ ____ *

* If this amount changes, this item will be revised.

C. The following formula is used to determine the amount:
_____
_____
_____

Note: If the amount protected for waiver recipients in 1. is **equal to, or greater than** the maximum amount of income a waiver recipient may have and be eligible under §435.217, **enter NA in items 2. and 3**. following.

2. spouse only (check one):

A.___ The following standard under 42 CFR 435.121:

B.___ The medically needy income standard_____;

C.___ The following dollar amount: $_____*

* If this amount changes, this item will be revised.

D.___ The following percentage of the following standard that is not greater than the standards above:_____% of

E.__X__ The following formula is used to determine the amount: For a spouse, subtract the maintenance allowance for an individual from the married couple amount specified in the Medicaid State Plan, Supplement 7 to Attachment 2.6A, Page 1.

F.___ Not applicable (N/A)

3. family (check one):

A.__X__ AFDC need standard

B.___ Medically needy income standard

The amount specified below cannot exceed the higher of the need standard for a family of the same size used to determine eligibility under the State's approved AFDC plan

or the medically income standard established under 435.811 for a family of the same size.

C.___ The following dollar amount:
$_____*

* If this amount changes, this item will be revised.

D.___ The following percentage of the following standard that is not greater than the standards above: ____% of _____standard.

E.___ The following formula is used to determine the amount:

F.___ Other

G.____Not applicable (N/A)

b. Medical and remedial care expenses specified in 42 CFR 435.735.

POST ELIGIBILITY

SPOUSAL POST ELIGIBILITY

2.___ The State uses the post-eligibility rules of §1924(d) of the Act (spousal impoverishment protection) to determine the individual's contribution toward the cost of home and community-based care if it determines the individual's eligibility under §1924 of the Act. There shall be deducted from the individual's monthly income a personal needs allowance (as specified below), and a community spouse's allowance, a family allowance, and an amount for incurred expenses for medical or remedial care, as specified in the State Medicaid plan.

(A) Allowance for personal needs of the individual:
(check one)

(a)___ SSI Standard

(b)___ Medically Needy Standard

(c)___ The special income level for the institutionalized

(d)___ The following percent of the Federal poverty level:
___%

(e)___ The following dollar amount
$___**

**If this amount changes, this item will be revised.

(f)___ The following formula is used to determine the needs allowance:

(g)__ Other (specify):

If this amount is different from the amount used for the individual's maintenance allowance under 42 CFR 435.726 or 42 CFR 435.735, explain why you believe that this amount is reasonable to meet the individual's maintenance needs in the community.

_____
_____
_____
_____
_____
_____

APPENDIX D
ENTRANCE PROCEDURES AND REQUIREMENTS

APPENDIX D-1

a. EVALUATION OF LEVEL OF CARE

The agency will provide for an evaluation (and periodic reevaluations) of the need for the level(s) of care indicated in item 2 of this request, when there is a reasonable indication that individuals might need such services in the near future, but for the availability of home and community-based services.

b. QUALIFICATIONS OF INDIVIDUALS PERFORMING INITIAL EVALUATION

The educational/professional qualifications of persons performing initial evaluations of level of care for waiver participants are (Check all that apply):

_____ Discharge planning team

_X_ Physician (M.D. or D.O.)

_____ Registered Nurse, licensed in the State

_X_ Licensed Social Worker

_____ Qualified Mental Retardation Professional, as defined in 42 CFR 483.430(a)

_x_ Other (Specify):
A "Community Mental Health Professional (QMHP)as defined in 405 Indiana Administrative Code 5-21-1. The final level of care determination will be made by a State Consultant III employed by the Office of Medicaid Policy and Planning with experience serving individuals with mental illness. (Note: The Level of Care assessment can only be done by an agency that also serves as a gatekeeper to the state hospitals.

APPENDIX D-2

a. REEVALUATIONS OF LEVEL OF CARE

Reevaluations of the level of care required by the individual will take place (at a minimum) according to the following schedule (Specify):

_____ Every 3 months

_____ Every 6 months

__X__ Every 12 months

_____ Other (Specify):_____

b. QUALIFICATIONS OF PERSONS PERFORMING REEVALUATIONS

Check one:

__x__ The educational/professional qualifications of person(s) performing reevaluations of level of care are the same as those for persons performing initial evaluations.

_____ The educational/professional qualifications of persons performing reevaluations of level of care differ from those of persons performing initial evaluations. The following qualifications are met for individuals performing reevaluations of level of care (Specify):

_____ Physician (M.D. or D.O.)

_____ Registered Nurse, licensed in the State

_____ Licensed Social Worker

_____ Qualified Mental Retardation Professional, as defined in 42 CFR 483.430(a)

_____ Other
(Specify):_____

c. PROCEDURES TO ENSURE TIMELY REEVALUATIONS

The State will employ the following procedures to ensure timely reevaluations of level of care (Check all that apply):

_____ "Tickler" file

__x__ Edits in computer system

__x__ Component part of case management

_____ Other (Specify):

APPENDIX D-3

a. MAINTENANCE OF RECORDS

1. Records of evaluations and reevaluations of level of care will be maintained in the following location(s) (Check all that apply):

_____ By the Medicaid agency in its central office

_____ By the Medicaid agency in district/local offices

_____ By the agency designated in Appendix A as having primary authority for the daily operations of the waiver program

_____ By the case managers

__x__ By the persons or agencies designated as responsible for the performance of evaluations and reevaluations

_____ By service providers

_____ Other (Specify):

_____
_____
_____

2. Written documentation of all evaluations and reevaluations will be maintained as described in this Appendix for a minimum period of 3 years.

b. COPIES OF FORMS AND CRITERIA FOR EVALUATION/ASSESSMENT

A copy of the written assessment instrument(s) to be used in the evaluation and reevaluation of an individual's need for a level of care indicated in item 2 of this request is attached to this Appendix.

For persons diverted rather than deinstitutionalized, the State's evaluation process must provide for a more detailed description of their evaluation and screening procedures for individuals to ensure that waiver services will be limited to persons who would otherwise receive the level of care specified in item 2 of this request.

Check one:

___x___ The process for evaluating and screening diverted individuals is the same as that used for persons transitioned from a hospital.

_____ The process for evaluating and screening diverted individuals differs from that used for deinstitutionalized persons. Attached is a description of the process used for evaluating and screening diverted individuals.

See Attached:

- **Hospital Level of Care Application Form**

Mental Health Hospital Level of Care

Application Form

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Introduction

This form enables a child to apply for a mental health hospital level of care (ILC). This care can be delivered through the home and community-based services/severe emotional disturbance (HCBS/SED) waiver or through a state hospital. It is divided into three major parts; *each part must be completed based upon a face-to-face interview with the child and family member(s) as well others means of gathering information such as medical records*.

Part 1: Identifying information. This portion of the ILC application contains sections for you to provide contact information for the child seeking services, his or her parent or guardian, and the child's case worker(s).

Part 2: Assessment information. This portion of the application contains questions that help determine the child's eligibility for services.

Part 3: Attachments. Some of the attachments are required with every ILC application; others are used only if an exception is requested for a child who would otherwise not qualify for services.

To qualify for services, a child must:

Be at least age 4 and under age 18; an exception is possible for youth, ages 18 through 21.

Meet the Severe Emotional Disturbance (SED) criterion; there is no exception.

Have a minimum score of 70 on two subscales of the appropriate version of the Achenbach System of Empirically Based Assessment (ASEBA):

Child Behavior Checklist for ages 1½-5 (CBCL/1½ -5)
Caregiver-Teacher Report Form for ages 1½ -5 (C-TRF)
Child Behavior Checklist for ages 6-18 (CBCL/6-18)
Teacher's Report Form for ages 6-18 (C-TRF)
Youth Self-Report for ages 6-18 (YSR)

Have an average item score on the Hoosier Assurance Plan Instrument – Children & Adolescents (HAPI-C) of less than or equal to 3.5 on any two listed factors; there is no exception.

Have received intermediate community-based services (ICBS). These services are defined as any one or combination of targeted case management, day treatment, or home-based therapy; an exception is possible for those who do not meet this criterion.

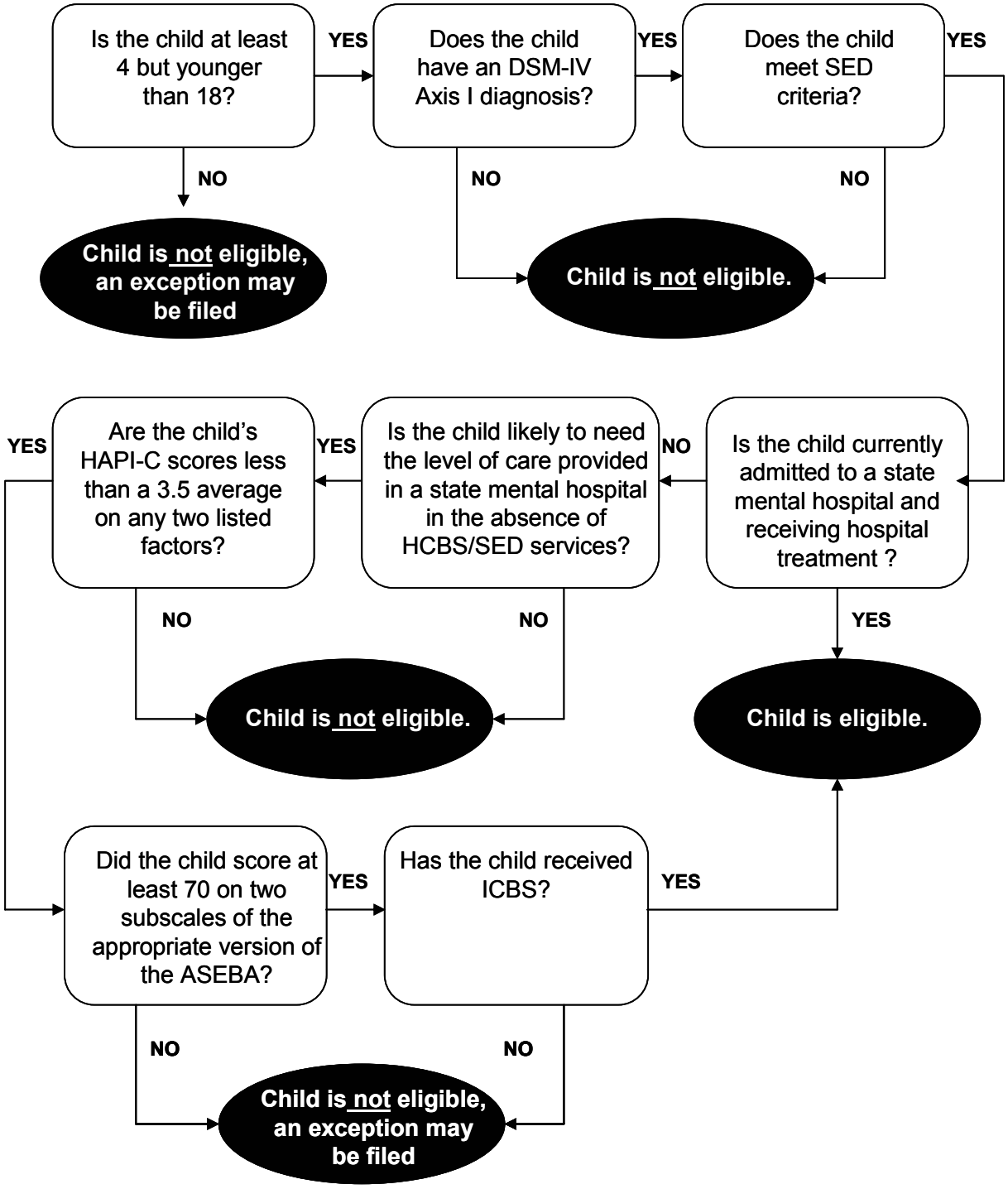
Eligibility for individuals meeting the criteria can be determined at the community mental health center (CMHC); decisions about exceptions for children who do not meet the criteria in items numbers 1, 3 and 5 must be determined at the state level for admission into the (HCBS/SED) waiver program but may be determined at the CMHC for admission into the state hospital.

The graphic on the next page depicts the decision flow for determining whether a child is eligible for a mental health hospital level of care. Eligibility for services does not necessarily mean space is available.

Maintain the original application form and supporting documentation at the CMHC. If an HCBS/SED waiver is requested, forward a copy of the completed application form, along with all relevant attachments, to:

HCBS/SED Waiver Manager
Office of Transitional Services, DMHA
402 W. Washington Street, W353
Indianapolis, IN 46204

Decision Flow for Determining Child's Eligibility for a Mental Health Hospital Level of Care



Mental Health Hospital Level of Care Application: Initial Clinical Eligibility

Type of Service Requested: ❑ Treatment within a state hospital ❑ An HCBS/SED waiver

PART 1. IDENTIFYING INFORMATION

Child's Identifying Information

Name:	(Last)	(First)	(MI)
Also Known As:	(Last)	(First)	(MI)
Also Known As	(Last)	(First)	(MI)
Date of Birth:	__ __ / __ __ / __ __ __ __	Sex: ❑ Male ❑ Female	
Preferred Language of Communication: ❑ English ❑ Spanish ❑ Other:			
Current Address:	❑ Home ❑ Treatment Setting ❑ Homeless (NO street address) ❑ Other:		
(Street)			
(City)		(State)	(Zip)
Telephone number:	( )		
Education/Vocation status:			

Referral Source

Name:	(Last)	(First)		(MI)
Agency:				
Address:	(Street)			
(City)			(State)	(Zip)
Email Address:		Telephone Number:	( )	

Parent/Guardian Identifying Information:

Name:	(Last)	(First)	(MI)
Relationship to child: ❑ Parent ❑ Guardian ❑ Grandparent ❑ Aunt/Uncle ❑ Other:			
Preferred Language of Communication: ❑ English ❑ Spanish ❑ Other:			
Current Address:	❑ Home ❑ Treatment Setting ❑ Homeless (NO street address) ❑ Other:		
(Street)			
(City)		(State)	(Zip)
Telephone number:	( )		

CHINS/Ward Custody? ❑ **NO** ❑ **YES** Case Number: _____

Case Worker Identifying Information (if applicable)

Name:	(Last)	(First)		(MI)
Address:	(Street)			
(City)		(County	(State)	(Zip)
Email Address:		**Telephone Number:**	( )	

Probation Officer Identifying Information (if applicable)

Name:	(Last)	(First)		(MI)
Address:	(Street)			
(City)		(County	(State)	(Zip)
Email Address:		**Telephone Number:**	( )	

PART 2. ASSESSMENT INFORMATION

1. Is the child at least 4 years but not yet 18 years old?

❑ **NO** (Go to number 9. To request an exception for youth ages 18 to 21, complete Attachment C)

❑ **YES** (Go to number 2.)

2. Does the child have a current DSM-IV, Axis I diagnosis? (Substance abuse diagnosis alone not sufficient.)

❑ **NO** (Child is not eligible. Go to number 9.)

❑ **YES** (Fill out the information below. Then go to number 3.)

Code numbers of primary diagnoses: _____

Date of most recent diagnosis: _____

Psychiatrist or HSPP psychologist making the diagnoses:

Name and credentials: _____

License number: _____

Agency: _____

Telephone number: ( )

Assessment Information (cont)

3. Does the child meet Severe Emotional Disturbance (SED) criterion?

❑ **NO** (Child is not eligible. Go to number 9.)

❑ **YES** (Fill out the information below. Then go to number 4)

Date of determination of SED: __ __/__ __ /__ __ __ __ (Determination must be within last 365 days)

Mental health professional making the SED determination

Name and credentials: _____

Agency: _____

Telephone number: ( )

4. Is the child currently admitted to a state mental health hospital and receiving hospital treatment services?

❑ **NO** (Go to number 5.)

❑ **YES** (Child is eligible for ILC. Attach copy of hospital service plan. Complete Attachment A. Then go to number 9.)

5. Is the child likely to need the level of care provided in a state mental health hospital in the absence of HCBS/SED services?

❑ **NO** (Child is not eligible for ILC. Go to number 9.)

❑ **YES** (Complete Attachments A and B. Then go to number 6.)

6. Record the results of the Hoosier Assurance Plan Instrument – Children and Adolescents (HAPI-C).

Date of HAPI-C: __ __/__ __ /__ __ __ __ *(Evaluation must be within last 30 days.)*

Indicate item averages:

Affective Symptoms (average of items 1, 2, 3)		School (average of items 13, 14, 15, 16)	
Suicidal ideation/behaviors (score of item 4)		Disruptive behaviors (average of items 17, 18, 19)	
Thinking (average of items 8, 9)		Substance abuse/use (average of items 20, 21, 22)	
Family (average of items 10, 11, 12)		Reliance on mental health services (score of item 24)	

Did the child score less than or equal to an average of 3.5 on each of two listed factors?

❑ **NO** (Child is not eligible for the ILC. Go to number 9.)

❑ **YES** (Go to number 7.)

Assessment Information (cont)
Item #6 (cont)

Mental health professional completing the HAPI-C:

Name and credentials: _____

Agency: _____

Telephone number: ( )

7. Record results of the appropriate version of the ASEBA.

*Date of the CBCL,*TRF,*YSR,* CBCL/1½ -5, or C-TRF: __ __/__ __/__ __ __ __ *(Scores must be within last 30 days.)*

Indicate scores on the version used:

SUBSCALES	CBCL 6-18 Scores	TRF 6-18 Scores	YSR 6-18 Scores	**SUBSCALES**	CBCL 1½-5 Scores	C-TRF 1½-5 Scores
Anxious/Depressed				*Emotionally Reactive*		
Withdrawn/Depressed				Anxious/Depressed		
Social Problems				*Withdrawn*		
Thought Problems				*Attention Problems*		
Attention Problems				*Aggressive Behavior*		
Rule-Breaking Behavior						
Aggressive Behavior						
Total Problems				**Total Problems**		

Did the child score at least 70 on two subscales? (e.g. Withdrawn, Anxious/Depressed, Thought Problems, etc.)

❑ **NO** (Child is not eligible for ILC. Go to number 9. If desired, you may apply for an exception.)

❑ **YES** (Go to number 8.)

Mental health professional scoring the ASEBA:

Name and credentials: _____

Agency: _____

Telephone number: ( )

Assessment Information (cont)

8.	Has child received intermediate community based services (ICBS)? ICBS is defined as any one or combination of the following CMHC-provided services: Targeted Case Management, Day Treatment, or Home Based Therapy. Complete Attachment E. **(Outpatient therapy or non-community mental health services are not considered ICBS.)** ❑ **NO** Child is not eligible for ILC. (Refer to ICBS or apply for an exception.) ❑ **YES** (Go to number 9)

9.	Select all that apply:	
	Child **is** eligible for ILC.	❑ Treatment is requested at a state hospital. ❑ Treatment is requested through the HCBS/SED Waiver. (Go to number 10.)
	Child is **not** eligible for ILC but exceptions are approved by the CMHC for treatment at a **state hospital.**	❑ Age 18 criterion (Complete Attachment C.) ❑ ASEBA scores (Complete Attachment D.) ❑ ICBS criterion (Complete Attachment E.) **Keep the application and all attachment on file at the CMHC.**
	Child is **not** eligible for ILC but exceptions are being requested through the state for treatment through the **HCBS/SED Waiver.**	❑ Age 18 criterion (Complete Attachment C.) ❑ ASEBA scores (Complete Attachment D.) ❑ ICBS criterion (Complete Attachment E.) **Forward the application and all attachment to the HCBS/SED Waiver Manager.** **(Wait for the Notice of Action and then go to number 10 if the exceptions are approved or to number 11 if the exceptions are denied.)**
	Child is **not** eligible for ILC.	❑ Exceptions were not requested. **(Go to number 11 for HCBS/SED ineligibility.)** ❑ Exceptions were denied. **(Go to number 11 for HCBS/SED ineligibility.)** ❑ Child does not meet HAPI-C criterion. **(Go to number 11 for HCBS/SED ineligibility.)** ❑ Child does not need the level of care provided by a state mental health hospital. **(Go to number 11 for HCBS/SED ineligibility.)** ❑ Child did not attain a t-score of 63-69 on the ASEBA. **(Go to number 11 for HCBS/SED ineligibility.)**

Assessment Information (cont)

10.	What date was the Notice of Action delivered, informing the child and family/caretaker that the child meets the eligibility criteria for the **HCBS/SED** waiver? (Go to *Prepared by* section.)	__ __/__ __/__ __ __ __
11.	What date was the Notice of Action delivered informing the child and family/caretaker that the child **does not** meet the eligibility criteria for the **HCBS/SED** waiver? (Go to number 12.)	__ __/__ __/__ __ __ __
12.	If the Notice of Action indicated that the child does not meet **HCBS/SED** eligibility criteria, on what date was the parent/guardian notified that an appeals process exists? (Go to number 13.)	__ __/__ __/__ __ __ __
13.	What date was the appeal: ❑ Filed (Go to number 14.) ❑ Declined (Go to *Prepared by* section.)	__ __/__ __/__ __ __ __
14.	What date was the appeal: ❑ Approved ❑ Denied (Go to *Prepared by* section.)	__ __/__ __/__ __ __ __

Persons Interviewed Face-to-Face: ❑ Child ❑ Family Members (list below)

(Printed name):		Date:
(Signature):	Telephone number:	( )
(Printed name):		Date:
(Signature):	Telephone number:	( )
(Printed name):		Date:
(Signature):	Telephone number:	( )

Prepared By:

(Printed name):			Date:
(Signature):	Telephone number:	( )	
Agency:			
Address:	(Street)		
(City)		(State)	(Zip)
Telephone Number:	( )		

ATTACHMENT A: SUMMARY OF CMHC CLINICAL ASSESSMENT
(Include additional pages as necessary)

Child's Name: _____ **Date:** __ __/__ __/__ __ __ __

1.	List the locations where child currently receives services. Specify the state mental health hospital, community health or child service providers:	
	Location	Date Admitted: *M M / D D / Y Y Y Y*

2.	List the community services that have been provided. List services provided for the past six months.				
	Service	Start Date *M M / D D / Y Y Y Y*	End Date *M M / D D / Y Y Y Y*	Frequency	Providers
	Targeted Case Mgmt				
	Day Treatment				
	Home-Based Therapy				

3.	List the acute services that have been provided. List services provided for the past three months.				
	Service	Start Date *M M / D D / Y Y Y Y*	End Date *M M / D D / Y Y Y Y*	Frequency	Providers

Attachment A (cont)

4.	Provide a summary of the clinical findings regarding the child's need for mental health hospital level of care. The documentation should be behaviorally focused and include the following items:
	Symptoms:
	Medications/Reason prescribed:
	Presenting Problems:
	Risk Factors:
	Clinical Impressions:
	Strengths and Resources Available to Child (e.g. family, education, spiritual, ability, etc):
	GAF Score: Current: __ __ Highest level of functioning in past year: __ __

Attachment A (cont)

5.	Provide a summary of the clinical findings regarding the child's prognosis with provision of mental health hospital level of care:	
	Expectation for child with waiver services:	
	Expectation for child without waiver services:	
	Anticipated length of stay:	
	Transition services (family/caregiver):	

Prepared By:

(Printed name):			Date:
(Signature):		Telephone number:	( )
Agency:			
Address:	(Street)		
(City)		(State)	(Zip)
Telephone Number:	( )		

ATTACHMENT B: CURRENT EVIDENCE SUPPORTING CHILD'S NEED FOR LEVEL OF CARE PROVIDED IN A STATE MENTAL HEALTH HOSPITAL

(Include additional pages as necessary)

Child's Name: _____ **Date:** __ __/__ __/__ __ __ __

1.	Describe the **specific** behaviors/problems that would prevent the child from remaining in their home without HCBS/SED services. Be sure to list **examples** of aggressive behaviors, assaultive behaviors, self-mutilation, animal cruelty, substance abuse, risky sexual behavior, etc.)

2.	Describe the child's family and current living situation that supports the need for HCBS/SED services. Be sure to be specific. Do not use general phrases. Describe in detail.

Attachment B (cont)

3.	Describe the factors in the child's school/vocational placement that support the need for HCBS/SED services. (e.g. aggressive behavior, reduced school day due to behavior problems, failed efforts to mainstream with assistance, difficulty remaining on task in self contained classroom, significantly below achievement level, formally identified as E.H. or S.E.H., previously applied for assistance from Department of Education, etc.) Describe in detail.

4.	Describe private outpatient therapy and non-clinical interventions and the extent to which they have or have not been successful in treating the child. (e.g. family and other support systems, YMCA services, church services etc.*)*

Prepared By:

(Printed name):		Date:
(Signature):	Telephone number:	( )

Agency:			
Address:	(Street)		
(City)		(State)	(Zip)
Telephone Number:	( )		

ATTACHMENT C: REQUEST FOR EXCEPTION TO AGE 18 CRITERION
(Include additional pages as necessary)

Youth's Name: _____ __

Date: __ __/__ __/__ __ __ __

1. Does the youth have a current DSM-IV, Axis I diagnosis? (Substance use diagnosis alone not sufficient.)

❑ **NO** (Youth is not eligible. (Go to number 9 on the *Initial Clinical Eligibility* form.)

❑ **YES** (Fill out the information below. Then go to number 2 on this attachment.)

Code numbers of primary diagnoses: _____

Date of most recent diagnosis: _____

Psychiatrist or HSPP psychologist making the diagnoses:

Name and credentials: _____

License number: _____

Agency: _____

Telephone number: ( )

2. Does the youth meet Seriously Mentally Ill (SMI) criterion?

❑ **NO** (Youth is not eligible. (Go to number 9 on the *Initial Clinical Eligibility* form.)

❑ **YES** (Fill out the information below. Then go to number 3 on this attachment.)

Date of determination of SMI: __ __/__ __ /__ __ __ __ (Determination must be within last 365 days)

Mental health professional making the SMI determination:

Name and credentials: _____

Agency: _____

Telephone number: ( )

3. Is the youth currently admitted to a state mental health hospital and receiving hospital treatment services?

❑ **NO** (Go to number 4 on this attachment.)

❑ **YES** (Youth is eligible for ILC. Attach copy of hospital service plan. Complete Attachment A. Then go to number 9 on the *Initial Clinical Eligibility* form.)

Attachment C (cont)

4.	Is the youth likely to need the level of care provided in a state mental health hospital in the absence of ILC services? ❑ **NO** (Youth is not eligible for ILC. (Go to number 9 on the *Initial Clinical Eligibility* form.) ❑ **YES** (Complete Attachments A and B. Then go to number 5 on this attachment.)

5. Record the results of the Hoosier Assurance Plan Instrument – Adults (HAPI-A).

Date of HAPI-A: __ __/__ __/__ __ __ __ *(Evaluation must be within last 30 days.)*

Indicate item averages:

Symptoms of Distress and Mood (average of items A, B, C)		Risk Behavior and Substance Abuse (average of items M, N1, N2, N3, N4, N5, N6)	
Community Functioning (average of items E, F, G, H)		Reliance on Mental Health Services (score of item O)	
Social Support-Skills and Housing (average of items I, J, K, L)			

Did the youth score less than or equal to an average of 3.5 on each of two listed factors?

❑ **NO** Youth is not eligible for ILC. (Go to number 9 on the *Initial Clinical Eligibility* form.)

❑ **YES** Fill in the information requested on who completed the HAPI-A. (Then go to number 6 on this attachment.)

Mental health professional completing the HAPI-A:

Name and credentials: _____

Agency: _____

Telephone number: ( )

Attachment C (cont)

6. Record results of the ASEBA Adult Self-Report for ages 18-59 (ASR) or the Adult Behavior Checklist for Ages 18-59 (ABCL).

Date of ASR or ABCL: __ __/__ __/__ __ __ __ *(Scores must be within last 30 days.)*

Indicate scores on the version used:

SUBSCALES	ASR Scores	ABCL Scores
Anxious/Depressed		
Withdrawn		
Thought Problems		
Attention Problems		
Aggressive Behavior		
Rule-Breaking Behavior		
Intrusive		
Total Problems		

Did the youth score at least 70 on two subscales? (e.g. Withdrawn, Somatic Complaints etc.)

❑ **NO** Youth is not eligible for ILC. Fill in the information requested on who completed the ABCL/ASR. (Go to number 9 on the *Initial Clinical Eligibility* form. If desired, you may apply for an exception.)

❑ **YES** Fill in the information requested on who completed the ABCL/ASR. (Go to number 7 on this attachment.)

Mental health professional scoring the ABCL, or ASR:

Name and credentials: _____

Agency: _____

Telephone number: ( )

7. Has ICBS been in place and continually provided to the youth at least six months prior to the date of the current clinical eligibility assessment? NOTE: Intermediate Community Based Service (ICBS) is defined as any one or combination of the following CMHC provided services: Targeted Case Management, Day Treatment, or Home Based Therapy ONLY. *Do not include outpatient therapy or non-CMHC services.*

❑ **NO**. Youth does not meet ILC criteria. (To apply for an exception, go to number 9 on the *Initial Clinical Eligibility* form.)

❑ **YES**. (Go to item 8 on this attachment.)

Attachment C (cont)

8.	List the community services that have been provided. List services provided for the past six months.				
	Service	Start Date *M M / D D / Y Y Y Y*	End Date *M M / D D / Y Y Y Y*	Frequency	Providers
	Targeted Case Mgmt				
	Day Treatment				
	Home-Based Therapy				

Comments: Describe other circumstances to be considered in waiving the age 18 criterion.

Prepared By:

(Printed name):	Date:
(Signature):	Telephone number: ( )

Agency:			
Address:	(Street)		
(City)		(State)	(Zip)
Telephone Number:	( )		

Exception Decision:

❑ Granted	❑ Denied	Decision Date __ __ / __ __ / __ __ __ __
Authorized by:	(Name and Title)	
Telephone Number:	( )	

ATTACHMENT D: REQUEST FOR EXCEPTION TO ASEBA CRITERION
(Include additional pages as necessary)

Child's Name: _____ Date: __ __/__ __/__ __ __ __

1. Was a t-score of 63 -69 attained for the child on *Total Problems*?
❑ **NO** Child does not meet ILC criteria. (Go to number 9 on the *Initial Clinical Eligibility* form.) ❑ **YES** (Document reasons for ASEBA exception in number 2 below.)

2. Explain why the ASEBA minimum score criterion should be excepted. For example, describe circumstances that interfere with attaining the minimum ASEBA score, or clinical observations that support exception of the minimum score. (e.g. language barrier, cultural values/beliefs, etc) Go to number 3 below.

3. Has an ASEBA been completed in the **6 months previous to this current clinical assessment** that attained a score of 70 or higher?

❑ **NO** ASEBA not previously administered. (Be sure to check with schools before marking this box.)
❑ **NO** ASEBA administered by score was less than 70. **Date completed:** __ __ /__ __ /__ __ __ __
❑ **YES** ASEBA administered and score was greater than 70. **Date completed:** __ __ /__ __ /__ __ __ __

Mental health professional scoring the ASEBA was:

Name and credentials: _____

Agency: _____

Telephone number: ( )

Attachment D (cont)

Prepared By:

(Printed name):		Date:
(Signature):	Telephone number:	( )

Agency:			
Address:	(Street)		
(City)		(State)	(Zip)
Telephone Number:	( )		

Exception Decision:

❑ Granted ❑ Denied	Decision Date __ __ / __ __ / __ __ __ __
Authorized by:	(Name and Title)
Telephone Number:	( )

ATTACHMENT E: REQUEST FOR EXCEPTION TO ICBS CRITERION
(Use additional pages as necessary)

Child's Name: _____ Date: __ __/__ __/__ __ __ __

1.	Document barriers to obtaining intermediate community based services (ICBS). (e.g. financial difficulties, services unavailable in the community, child in residential care, group home, DOC, etc.)

2.	Describe other circumstances to be considered to support need for HCBS/SED waiver or admission to a state hospital even though ICBS have not been provided to the child and family. Please be specific.

Attachment E (cont)

Prepared By:

(Printed name):	Date:
(Signature):	Telephone number: ( )

Agency:			
Address:	(Street)		
(City)		(State)	(Zip)
Telephone Number:	( )		

Exception Decision:

❑ **Granted**	❑ **Denied**	**Decision Date __ __ / __ __ / __ __ __ __**
Authorized by:	(Name and Title)	
Telephone Number:	( )	

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APPENDIX D-4

a. FREEDOM OF CHOICE AND FAIR HEARING

1. When an individual is determined to be likely to require a level of care indicated in item 2 of this request, the individual or his or her legal representative will be:

   a. informed of any feasible alternatives under the waiver; and

   b. given the choice of either hospital or home and community-based services.

2. The agency will provide an opportunity for a fair hearing under 42 CFR Part 431, subpart E, to individuals who are not given the choice of home or community-based services as an alternative to the hospital care indicated in item 2 of this request or who are denied the service(s) of their choice, or the provider(s) of their choice.

3. The following are attached to this Appendix:

   a. A copy of the form(s) used to document freedom of choice and to offer a fair hearing;

   b. A description of the agency's procedure(s) for informing eligible individuals (or their legal representatives) of the feasible alternatives available under the waiver;

   c. A description of the State's procedures for allowing individuals to choose either hospital or home and community-based services; and

   d. A description of how the individual (or legal representative) is offered the opportunity to request a fair hearing under 42 CFR Part 431, Subpart E.

b. FREEDOM OF CHOICE DOCUMENTATION

Specify where copies of this form are maintained:

Forms will be maintained at the agency that provides wraparound facilitation services.
Attached please find:

- Description of Forms Used to Document Freedom of Choice and Offer a Fair Hearing
- Plan of Care/Cost Comparison Budget
- Notice of Action
- Statement of Freedom of Choice (Wraparound Facilitation agency, Recipient, DMHA)

Description of Form Used to Document Freedom of Choice and to Offer a Fair Hearing:
The waiver recipient/guardian signs and dates a "Statement of Freedom of Choice Form" indicating a choice of either services in a hospital setting or home and community-based waiver services. The Medicaid Waiver Services Wraparound Facilitator is responsible for explaining the array of services available in a hospital setting as well as the feasible alternatives available through the Medicaid HCBS Waiver program.

Notice of Action: (State Form 46015-HCBS Form 5) is a written statement used to notify each Medicaid applicant/recipient of any action that affects the individual's Medicaid Waiver benefits (as per Federal regulations for the Medicaid program at 42 CFR 431.200). An "action" may be a termination, reduction, or increase of all or any amount of waiver services. This also includes actions taken to approve or deny new applications. The Notice of Action is a written statement sent to the waiver applicant/recipient that explains:

- The action to be taken;
- The reason(s) for the intended action(s);
- The date the action will take place;
- The specific Federal or State regulation(s) that supports or requires the action being taken. (This is mandatory for adverse actions that terminate, suspend, reduce, or deny waiver services); and
- The parent/guardian's appeal rights

A Description of the Agency's Procedure(s) for Informing Eligible Individuals (or Their Legal Representatives) of the Feasible Alternatives Available Under the Waiver:
It is the responsibility of the Medicaid Waiver Services Wraparound Facilitator to inform the parent/guardian of the services available in a hospital setting and the array of services available to meet that individual's needs through the Medicaid HCBS Waiver program. The individual is informed that in order to be eligible for the waiver program, the costs of those services may not exceed the costs of hospital care.

A Description of the State's Procedures for Allowing Parent/Guardians to Choose Either Hospital or Home and Community Based Services:
Eligible individuals are provided with a choice of either hospital or home and community based services through the use of the Statement of Freedom of Choice form. It is the responsibility of the Medicaid Waiver Services Wraparound Facilitator to fully inform the parent/guardian of the services available in a hospital setting and the array of services available to meet the needs of the individual through the Medicaid HCBS Waiver. After becoming familiar with the alternatives, the parent/guardian is provided the opportunity to decide which option best serves the child's needs. Language contained in the Statement for Freedom of Choice form verifies that the parent/guardian has been fully informed of the services available in the hospital setting and the feasible alternatives under the HCBS Waiver, and that the parent/guardian has made an informed, voluntary choice. Parents/guardian's who choose to have their child's needs met through the Medicaid HCBS Waiver are asked to make an informed choice about the services they want to receive to meet their need, and from which approved provider they want to receive the services.

A Description of How the Parent (or Legal Representative) is Offered the Opportunity to Request a Fair Hearing Under 42-CFR Part 431, Subpart E:
The Notice of Action (State Form 46015-HCBS Form 5): Federal regulations for the Medicaid program (42 CFR 431.200) require that each Medicaid applicant/recipient be informed of any action that affects the individual's Medicaid benefits. An "Action" may be a termination, reduction, or suspension of eligibility or any amount of covered services. This is also includes actions taken to approve or deny new applicants. State Form 46015-HCBS Form 5 is used to notify each Medicaid Waiver applicant/recipient/parent/guardian of any action that affects the individual's Medicaid Waiver benefits. An explanation regarding a waiver service recipient's appeal rights and the opportunity for a fair hearing is found on the back of the form. Part 2 "Your Right to Appeal" provides instructions for individuals regarding the procedures that are necessary in the appeal process.

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Notice of Action

Home and Community Based Services/Serious Emotional Disturbance Waiver

Name:	Medicaid Number
Address:	County:
Address 2:	Mailing date of notice
City, State, ZIP:	

☐ **NEW APPLICATION** ☐ **ANNUAL REDETERMINATION** ☐ **CHANGE/UPDATE**

The Indiana Family and Social Services Administration has taken the action indicated below in regard to your application for, or changes of services under the Home and Community-Based Services (HCBS) Waiver Program.

FOR APPLICATION ONLY

Effective _____your application for waiver services is ☐ Approved ☐ Denied ☐ Re-started

Level of Care ☐ Hospital

Reason

TO BE COMPLETED FOR ANNUAL REDETERMINATION, CHANGE/UPDATE, & DISCONTINUANCE ONLY

Effective _____your waiver services are ☐ Increased ☐ Decreased ☐ Discontinued ☐ Continued

Redetermination of Level of Care Completed? ☐ Yes ☐ No

Reason

Description of change

SERVICES APPROVED

Provider	Service	Start Date	Stop Date	Total Units	Average Units/Month

Signature of Case Manager	Case Mgr 9 digit authorization #	Case Mgr 4 digit I.D. #
Date		

IF YOU WISH TO APPEAL, PLEASE READ THE INFORMATION ON THE NEXT PAGE AND SIGN AND DATE BELOW

☐ I WISH TO APPEAL THE ABOVE DECISION	Reason:
Signature of applicant/recipient/guardian:	Date

See last page of this form for important information about your responsibilities and appeal rights.

Page 1 of 2

YOUR APPEAL RIGHTS AS AN HCBS WAIVER SERVICES RECIPIENT

1. If you question the above action, you should discuss this matter with your waiver services case manager.

2. **Your Right to Appeal and Have a Fair Hearing:**

If your application is denied, you may file an appeal within 30 days of the date the notice is **mailed** to you.

As an HCBS waiver recipient, if you disagree with any action taken on your HCBS waiver case, you may appeal within 30 days of the **effective date** of the action. However, your HCBS waiver benefits will not continue unless you appeal **prior to the effective date of action.** If you appeal and your waiver benefits are continued and you lose the appeal, you may be required to repay assistance paid in your behalf pending the release of the hearing decision.

3. **How to Request an Appeal:**

If you wish to appeal this decision, you may request an appeal within 30 days of the date of receipt of this decision. Sign and return this form ***or*** send a letter with your signature to: MS04, Indiana Family and Social Services Administration, Hearings and Appeals, 402 W Washington St., Room W392, Indianapolis, IN 46204.

If you send a letter rather than this Notice of Action, be sure that the letter contains your full name, address, and telephone number where you can be reached. Please attach a copy of this decision and state the name of the action you are appealing. A telephone request for an appeal cannot be accepted.

You will be notified in writing by the Family and Social Services Administration, Hearings and Appeals of the date, time, and place for the hearing. Prior to, or at the hearing, you have the right to examine the entire contents of your case record maintained by the waiver case manager.

You may represent yourself at the hearing or you may authorize a person to represent you, such as an attorney, relative, or other spokesperson. At the hearing you will have full opportunity to bring witnesses, establish all pertinent facts and circumstances, advance any arguments without interference and question, or refute any testimony or evidence presented.

Distribution of Notice of Action:

☐ Recipient ☐ County DFC ☐ Assessment Agency (CMHC) ☐ Provider(s) ☐ Waiver Case File

☐ DMHA Case File ☐ Other

Form: Appeal Rights – SED Waiver 06/03

Statement of Freedom of Choice

☐ SED Waiver

A Medicaid Waiver Services case manager/wraparound facilitator has explained the array of available services available to meet my needs through the Medicaid Home and Community-based services Waiver.

SECTION I: CHOICE BETWEEN HOSPITAL PLACEMENT AND SED WAIVER SERVICES

SERVICES AVAILABLE

☐ State Hospital ☐ SED Waiver

I have been fully informed of the services available to me in a hospital setting. I understand the alternatives available and have been given the opportunity to choose between waiver services in home and community-based settings and hospital care.

I understand that in order to be eligible for Medicaid Waiver Services, the costs of waiver services in home and community-based settings must comply with waiver programmatic cost-effectiveness.

As long as I remain eligible for waiver services, I will continue to have opportunity to choose between waiver services in home and community-based settings and hospital care.

CHOICE OF PROVIDER(S) AND SERVICE

☐ At this time I have chosen to receive waiver services in home and community-based settings, rather than services in a hospital setting.

☐ I have been informed of my right to choose any certified waiver provider when selecting waiver service providers.

☐ At this time I have chosen to receive services in a hospital setting, rather than waiver services in home and community-based settings.

SIGNATURES

Signature of recipient	Date signed (month, day, year)
Signature of: Check one ☐ Family ☐ Guardian ☐ Witness	Date signed (month, day, year)
Signature of case manager/wraparound facilitator	Date signed (month, day, year)

SECTION II: CHOICE BETWEEN HCBS WAIVER AND MEDICAID MANAGED CARE

NOTE: This section should be completed if a "Targeted" HCBS waiver applicant is currently on a Medicaid Managed Care program or if an HCBS waiver recepient wants to transfer to a Medicaid Managed Care program (if eligible). An individual cannot be on a

Choice of Program

(To be completed after all eligibility determinations have been made.)

I have been fully informed of the array of services available under the HCBS Waiver program and the Medicaid Managed Care Program.

☐ At this time, I have chosen to receive HCBS Waiver services, rather than Medicaid Managed Care Services.

☐ At this time, I have chosen to receive Medicaid Managed Care services, rather than HCBS Waiver services.

SIGNATURES

Signature of recipient	Date signed (month, day, year)
Signature of: Check one ☐ Family ☐ Guardian ☐ Witness	Date signed (month, day, year)
Signature of case manager/wraparound facilitator	Date signed (month, day, year)

DISTRIBUTION: ☐ Original - Waiver Case File ☐ Copy - Recipient ☐ Copy - CMHC Case File ☐ Copy - DMHA File

APPENDIX E - PLAN OF CARE
APPENDIX E-1

a. PLAN OF CARE DEVELOPMENT

1. The following individuals are responsible for the preparation of the plans of care:

_____ Registered nurse, licensed to practice in the State

_____ Licensed practical or vocational nurse, acting within the scope of practice under State law

_____ Physician (M.D. or D.O.) licensed to practice in the State

_____ Social Worker (qualifications attached to this Appendix)

_____ Case Manager

__x__ Other (specify):
Wraparound Facilitators

2. Copies of written plans of care will be maintained for a minimum period of 3 years. Specify each location where copies of the plans of care will be maintained.

_____ At the Medicaid agency central office

_____ At the Medicaid agency county/regional offices

_____ By case managers

_____ By the agency specified in Appendix A

__x__ By consumers

__x__ Other (specify):
Wraparound Facilitation provider agencies and DMHA.

3. The plan of care is the fundamental tool by which the State will ensure the health and welfare of the individuals served under this waiver. As such, it will be subject to periodic review and update. These reviews will take place to determine the appropriateness and adequacy of the services, and to ensure that the services furnished are consistent with the nature and severity of the individual's disability. The minimum schedule under which these reviews will occur is:

X	Every 3 months
	Every 6 months
	Every 12 months
x	Other (specify): As needed based on child needs.

APPENDIX E-2

a. MEDICAID AGENCY APPROVAL

The following is a description of the process by which the plan of care is made subject to the approval of the Medicaid agency:

Wraparound Facilitators will authorize initial provisional Plans of Care to allow the Child and Family Team to convene to develop the comprehensive Plan of Care within 60 days. Based on the terms and conditions of this waiver, the Medicaid agency may overrule the approval or disapproval of any specific Plan of Care acted upon by the Indiana Division of Mental Health and Addiction (DMHA) serving in its capacity as the administrating agency for this waiver program. Plans of care will be monitored by the HCBS/SED Waiver Manager at DMHA. Plans of care with costs over $3000 in any one quarter or over $12,000 annually will require approval by the authorized DMHA staff. Medicaid may review the plans of care and process at any time and will provide consultation.

b. STATUTORY REQUIREMENTS AND COPY OF PLAN OF CARE

1. The plan of care will contain, at a minimum, the type of services to be furnished, the amount, the frequency and duration of each service, and the type of provider to furnish each service.

2. A copy of the plan of care form to be utilized in this waiver is attached to this Appendix.

Attached are:

- PROVISIONAL PLAN OF CARE
- COMPREHENSIVE PLAN OF CARE

VERSION 06-95

PROVISIONAL PLAN OF CARE

Recipient's Name:	DOB: LOC Approval Date
Medicaid Number (RID):	Date Plan Completed:
Address:	
Telephone:	Parent/Guardian:

Presenting Problem: (Describe problem and need for provisional plan of care.)

Initial Plan – Effective From: To: Proposed Slot Number:

Medicaid State Plan and Waiver Services	Provider	Total Units	Cost per Unit	Monthly Cost	Total Annual Cost	Start Date	End Date
Wraparound Facilitation							

VERSION 06-95

PLAN OF CARE/COST COMPARISON BUDGET
CHILDREN WITH SERIOUS EMOTIONAL DISTURBANCES (SED WAIVER)

Recipient Last Name:_____**First**_____ **Middle**_____

Address_____**City** _____ **Zip**_____

DOB: _____**SSN**_____ **Medicaid Number**_____

LOC Decision Date_____ **LOC Previous Approval Date**_____ **LOC Pending? Yes** ☐ **No** ☐

☐ **Initial POC/CCB** ☐ **Quarterly POC/CCB** ☐ **Update POC/CCB** ☐ **Re-entry--Previous Termination Date** _____

Medicaid Eligibility Date_____ **Parental Income Excluded Yes** ☐ **No** ☐

LIFE DOMAINS: STRENGTHS & NEEDS (Describe the child's and/or family's/caretaker's problems, issues, and needs. Include strengths/assets which are relevant to meeting the needs.)

LIFE DOMAINS	**STRENGTHS**	**NEEDS**
Home		
Community		
Financial/Economic		

Health		
Legal		
Leisure/Recreation		
Vocational/Educational		
Socialization		
Other		

PRESENTING PROBLEM: (Describe child's problem/needs prior to the plan of care)

STATEMENT OF GOALS/OUTCOMES
(Describe how the child will function when all objectives are met. Examples: Child (name) will have no evidence of suicidal thoughts or gestures. Child will attend full day of school without running away.)

Outcome Objectives	Service and Support Needed	Responsible Person	Duration and Frequency	Total Units
1.				

2.				
3.				
4.				
5.				
6.				

CRISIS PLAN

Potential Crisis	Child Responds Well to:	Action Steps
1.		
2.		
3.		

(Crisis cont.) Person Responsible	Services and Supports Needed	Duration and Frequency
1.		

2.		
3.		

☐ I have reviewed the services contained in this plan and I choose to accept this plan and the services explained to me.

Signature of Applicant/Parent/Guardian_____Date_____

Signature of Representative_____Relation_____Date_____

Signature of Wraparound Facilitator_____Date_____

Signature of DMHA Waiver Manager_____Date_____

Quality Improvement Processes
Home and Community Based Waiver for Children with SED

DMHA has in place quality assurance and quality improvement processes that assist the state in monitoring the entire service system and in resolving significant complaints and/or incidents. These processes include:

1. A HCBS/SED Manager will oversee the model waiver, working closely with providers regarding standards, training, and monitoring the waiver. (See Job Description.)
2. INSITE, an electronic monitoring system, will be used to monitor and manage the waiver.
3. Provider & Service Standards. FSSA requires any agency or individual providing care through the waiver program, to meet certain standards. For example, an individual providing Independent Living/Skill Build services must have completed training, undergo a criminal background check, be healthy, and at least 21 years old. Agencies providing waiver services must document that they meet required standards and sign an agreement that they will adhere to these standards.
4. A Wraparound Facilitator submits the Plan of Care (with the identified services and the providers you choose for each service) to the Division of Mental Health and Addiction (DMHA). The DMHA Waiver Manager reviews Plans of Care to confirm the appropriateness based on the person's needs. DMHA has staff dedicated to completing on site surveys of providers and wraparound facilitators based on these standards. When significant issues are found during a survey, the provider and/or wraparound facilitator is required to complete corrective action, and DMHA reviews the actions taken to assure that the issues are resolved satisfactorily.
5. Outcome measures will be monitored for children participating in the waiver. Measures include level of functioning and level of environmental restrictiveness (ROLES). Providers are given feedback based on the outcomes for the children they serve as compared with children served elsewhere in the state.
6. Complaint Process. People receiving services, families/guardians, providers, and case managers and others can file formal complaints with DMHA through the Consumer Service Line. Calls are taken Monday through Friday, 8:30 a.m to 5 p.m. (800-901-1133) Community Consultants work with consumers and providers to investigate and resolve issues. Complaints/comments are tracked in a data base.
7. Incident Reporting Process. All providers of waiver services must report any incidents of suspected abuse, neglect or exploitation with Adult Protective Services or Child Protective Services. In addition, all providers of mental health treatment and support services in community settings, including waiver services, must file an incident report with the DMHA when a critical incident occurs. DMHA establishes definitions of what constitutes critical, reportable incidents. DMHA maintains a database of incidents.

Home and Community Based Waiver for Children with SED
Quality Improvement Processes

8. Other Quality Improvement Activities. In addition to the processes summarized above, DMHA has in place the following quality improvement activities that assist the Division in evaluating and making positive changes to the service delivery system.

a. Report Cards. DMHA contracts with IU to completed Report Cards for provider services. Report Cards focus on different consumer populations. Results are published on the web site.
b. Mental Health Advisory Council, made up of wide range of stakeholders, including consumers and advocates, works closely with DMHA in the planning and development of the mental health block grants and special projects.
c. An Ad Hoc Task Force, representing consumers, advocates, providers, the Office of Medicaid Policy and Planning, and all state agencies or systems that serve children worked on the development of the HCBS/SED Waiver from May, 2002 to May 2003. The partnerships with the Department of Correction and Department of Education, both providing state matching dollars, provide additional oversight, interest in outcomes, and monitoring.
d. A Policy Development Committee (PDC) reviews provider and service standards for all hospital and community based services, develops policy and rules to address emerging issues. Input is sought from stakeholders throughout the process.
e. Mortality Review Committee, which reviews information about the deaths of people with mental illness and receiving services through DMHA, identifies trends, suggests training needs, and develops recommendations that are designed to improve the quality of services.
f. Electronic Data Systems (EDS) the fiscal contractor of the Office of Medicaid Policy and Planning (OMPP) receives Medicaid Waiver claims and provider reimbursements to providers. OMPP contracts with EDS to review waiver providers as part of OMPP's monitoring and oversight of the SED Waiver.

APPENDIX F - AUDIT TRAIL

a. DESCRIPTION OF PROCESS

1. As required by sections 1905(a) and 1902(a)(32) of the Social Security Act, payments will be made by the Medicaid agency directly to the providers of waiver and State plan services.

2. As required by section 1902(a)(27) of the Social Security Act, there will be a provider agreement between the Medicaid agency and each provider of services under the waiver.

3. Method of payments (check one):

X Payments for all waiver and other State plan services will be made through an approved Medicaid Management Information System (MMIS).

_____ Payments for some, but not all, waiver and State plan services will be made through an approved MMIS. A description of the process by which the State will maintain an audit trail for all State and Federal funds expended, and under which payments will be made to providers is attached to this Appendix.

_____ Payment for waiver services will not be made through an approved MMIS. A description of the process by which payments are made is attached to this Appendix, with a description of the process by which the State will maintain an audit trail for all State and Federal funds expended.

_____ Other (Describe in detail):

b. BILLING AND PROCESS AND RECORDS RETENTION

1. Attached is a description of the billing process. This includes a description of the mechanism in place to assure that all claims for payment of waiver services are made only:

   a. When the individual was eligible for Medicaid waiver payment on the date of service;

   b. When the service was included in the approved plan of care;

   c. In the case of supported employment, prevocational or educational services included as part of habilitation services, when the individual was eligible to receive the services and the services were not available to the individual through a program funded under section 602(16) or (17) of the Individuals with Disabilities Education Act (P.L. 94-142) or section 110 of the Rehabilitation Act of 1973.

   _____ Yes

   ___x___ No. These services are not included in this waiver.

2. The following is a description of all records maintained in connection with an audit trail. Check one:

   ___X___ All claims are processed through an approved MMIS.

   _____ MMIS is not used to process all claims. Attached is a description of records maintained with an indication of where they are to be found.

3. Records documenting the audit trail will be maintained by the Medicaid agency, the agency specified in Appendix A (if applicable), and providers of waiver services for a minimum period of 3 years.

DESCRIPTION OF BILLING PROCESS

All payments for waiver and State Plan services furnished to program participants will be made via the processing of provider claims through Indiana's Medicaid Management Information System. All waiver services will be assigned special procedure codes. Special coding will be employed to identify Medicaid waiver eligible recipients as HCBS waiver program participants, based on approval of the Plan of Care.

Provider agency billings will be periodically reviewed by the individual Wraparound Facilitator to verify that only services authorized on the Plan of Care have been billed. The Indiana Division of Mental Health and Addiction, under the supervision of the Indiana Office of Medicaid Policy and Planning, conducts periodic performance audits of provider agencies to assure that billings are in alignment with the services authorized under the Plan of Care.

Additional Funding Assurances:

1) Providers of services under the SED Waiver retain 100 percent of the payments (state and federal share) provided for under the waiver. Providers are not required to return any portion of their payments to the State.

2) The state share of SED Waiver services is provided by funds appropriated by the Indiana General Assembly to the Office of Medicaid Policy and Planning (OMPP) and the Indiana Division of Mental Health and Addiction (DMHA), The Indiana Department of Correction (IDOC), and the Indiana Department of Education (IDOE). All funds are 100% state dollars.

   Indiana estimates that SED waiver service expenditure for the first 3 years will be $5.8 million. State match for this time period is estimated to be $2 million (year 1 $223,000, year 2 $890,000, and year 3, $910,000).

3) No supplemental or enhanced payments are made to SED Waiver providers.

4) No SED Waiver providers are public providers (defined as owned or operated by a government entity.

5) Indiana assures that none of the State share of payment for waiver services will be derived from Federal sources, including any Federal funding for services provided by the Community Mental Health Centers.

c. PAYMENT ARRANGEMENTS

1. Check all that apply:

_____ The Medicaid agency will make payments directly to providers of waiver services.

__X__ The Medicaid agency will pay providers through the same fiscal agent used in the rest of the Medicaid program.

_____ The Medicaid agency will pay providers through the use of a limited fiscal agent who functions only to pay waiver claims.

_____ Providers may *voluntarily* reassign their right to direct payments to the following governmental agencies (specify):

Providers who choose not to voluntarily reassign their right to direct payments will not be required to do so. Direct payments will be made using the following method:

2. Interagency agreement(s) reflecting the above arrangements are on file at the Medicaid agency.

APPENDIX G - FINANCIAL DOCUMENTATION

APPENDIX G-1
COMPOSITE OVERVIEW
COST NEUTRALITY FORMULA

INSTRUCTIONS: Complete one copy of this Appendix for each level of care in the waiver. If there is more than one level (e.g. hospital and nursing facility), complete an Appendix reflecting the weighted average of each formula value and the total number of unduplicated individuals served.

LEVEL OF CARE: Inpatient State Hospital Care

YEAR	FACTOR D	FACTOR D'	FACTOR G	FACTOR G'
1	$12,813	$ 9061	$54,513	$2,007
2	$12,813	$9,786	$54,513	$2,167
3	$13,107	$10,569	$55,603	$2,341
4	xxxx	xxxx		
5	xxxx	xxxx		

Note: The total estimated Medicaid costs for waiver recipients for waiver and non-waiver services are consistent with the experience of other waiver states.

Source. Comparison with Other States' Experience with 1915 (c) waivers for children with SED. Three other states have implemented 1915c waivers for children with SED: Vermont, New York, and Kansas. New York's waiver grew from 25 to 354 children by November 2002. Kansas has implemented the waiver statewide through systems of care; about 1200 children are being served with no waiting list. Similarities can be made between Kansas and Indiana both midwestern; Indiana has 92 counties, Kansas 96; both have silos of agencies serving children with SED-child welfare, juvenile justice, corrections, special education; both have state hospitals serving children with community mental health centers (CMHCs) as gatekeepers. Kansas has about 36 CMHCs; Indiana has 31.

In each of the waiver states, the per child costs of waiver services has been about half of the per child hospital costs. In each of the waiver states, the per child costs of waiver services has been about half of the per child hospital.

Phase-In/Out Schedule
State of Indiana
SED Waiver
Waiver Year: 1
2004

Month	Days Enrolled	Phase-In	Phase-Out	Total Days
Continuing Recipients	0			-
January-04	366	5	0	1,830
February-04	335	5	0	1,675
March-04	306	5	0	1,530
April-04	275	5	0	1,375
May-04	245	5	0	1,225
June-04	214	5	0	1,070
July-04	184	5	0	920
August-04	153	5	0	765
September-04	122	5	1	488
October-04	92	2	1	92
November-04	61	2	1	61
December-04	31	1	1	-
		50	4	11,031
Unduplicated Count		50		
Average Length of Stay		221		

Indiana

Phase-In/Out Schedule
State of Indiana
SED Waiver
Waiver Year: 2
2005

Month	Days Enrolled	Phase-In	Phase-Out	Total Days
Continuing Recipients	365	46		16,790
January-05	365	20	5	5,475
February-05	334	20	5	5,010
March-05	306	20	5	4,590
April-05	275	20	5	4,125
May-05	245	20	5	3,675
June-05	214	10	5	1,070
July-05	184	10	5	920
August-05	153	10	5	765
September-05	122	9	1	976
October-05	92	5	1	368
November-05	61	5	1	244
December-05	31	5	1	124
		200	44	44,132
			1	
Unduplicated Count		200		
Average Length of Stay		221		

Indiana page 83 10/03R

se-In/Out Schedule
e of Indiana
SED Waiver
ver Year: 3
2006

Month	Days Enrolled	Phase-In	Phase-Out	Total Days
Continuing Recipients	365	156		56,940
January-06	365	5	10	(1,825)
February-06	334	5	10	(1,670)
March-06	306	5	10	(1,530)
April-06	275	5	10	(1,375)
May-06	245	5	10	(1,225)
June-06	214	5	10	(1,070)
July-06	184	5	10	(920)
August-06	153	5	10	(765)
September-06	122	4	10	(732)
October-06	92	0	5	(460)
November-06	61	0	5	(305)
December-06	31	0	5	(155)
		200	105	44,908
Unduplicated Count		200		
Average Length of Stay		225		

Home and Community Based Waives for Children with SED
States' Experiences: Per-Child Costs (2001 Data)

Kansas: Average annual per-child costs $12,900, compared with institutional costs of $25,600.
Vermont: Average annual per-child costs $23,344, compared with inpatient costs of $52,988.
New York: Approximate annual per child costs $40,000, compared with institutional costs of $77,429.

(Bazelon, *Avoiding Cruel Choices*, 2002

FACTOR C: NUMBER OF UNDUPLICATED INDIVIDUALS SERVED

YEAR	UNDUPLICATED INDIVIDUALS
1	50
2	200
3	200
4	
5	

EXPLANATION OF FACTOR C:

Check one:

__x__ The State will make waiver services available to individuals in the target group up to the number indicated as factor C for the waiver year.

____ The State will make waiver services available to individuals in the target group up to the lesser of the number of individuals indicated as factor C for the waiver year, or the number authorized by the State legislature for that time period.

The State will inform HCFA in writing of any limit, which is less than factor C for that waiver year.

First Year-Calculation of Factor C
Number of unduplicated individuals served under the waiver.

Data Source:

The number of recipients expected to be served under the waiver was obtained from three data sources. The following sources of date and information were used as a proxy to estimate the number of individuals to be served under the waiver:

- National prevalence rates for children with serious emotional disturbances (Friedman, Katz-Leavy, Manderscheid & Sondheimer, 1996) and statewide population data for Indiana (Census, 2000). There are 1.5 million children in Indiana. From the prevalence literature, the number of youth with mental health issues in Indiana can be estimated. In 1996, 15.24% of Indiana's children were living in poverty, placing Indiana in the lower one-third of states. The methodology for determining prevalence of SED adjusts to incorporate the relative risk for SED caused by poverty. For the third of states with lower poverty levels, revised percentages (9 to 11% for SED with 5 to 7% for extreme impairment) are recommended.

- Comparison with Other States' Experience with 1915(c) waivers for children with SED. Three other states have implemented 1915(c) waivers for children with SED: Vermont, New York, and Kansas. New York's waiver grew from 25 to 354 children by November 2002. Kansas has implemented the waiver statewide through systems of care; about 1300 children are being served with no waiting list. Similarities can be made between Kansas and Indiana …both Midwestern; Indiana has 92 counties; Kansas 96; both have silo of agencies serving children with SED-child welfare, juvenile justice, corrections, special education; both have state hospitals serving children with community mental health centers (CMHCs) as gatekeepers. Kansas has 3+CMHCs; Indiana has 31. Kansas's 1995 estimate of prevalence for SED was 37,647 to 75,293 children. Their waiver has been implemented statewide using a system of care model. The eligibility screening criteria and instrument used in Kansas are similar to the criteria and instrument that have been adopted in Indiana.

- Community Services Data System report from FY2002. This data identified 22,046 children with serious emotional disturbances who were served by community mental health centers or other DMHA child providers.

Analysis and Calculations

- The Indiana HCBS/SED waiver will be a model waiver for three years, serving 50 children the first year, then 200 during the second and third years, depending on state resources for match. Estimates of the statewide need for this level of care will be refined based on the experience of the pilot model waiver sites.

Prevalence of Children with Serious Emotional Disturbances in Indiana.

Population	Number	Percent	Source
Total Indiana Population	6,080,485	100%	2000 Census
Children under 18	1,574,396	26% of total	2000 Census
Children (9-17)	799,477	50% of children	2000 Census
Children with DSMIV Diagnosis	314,879	20% of children	CMHS1996***
Children with Substantial Functional Impairment (ages 9 to 17) (SED)	71,952 to 87,842	9 to 11%	Friedman, Katz-Leavy, Manderscheid & Sondheimer, 1996
Children with Extreme Functional Impairment - (9 to 17) (SED with complex needs)	39,973 to 55,963	5 to 7%	Friedman, Katz-Leavy, Manderscheid & Sondheimer, 1996
Number of children served by DMHA in the community (SFY2002)(<200% poverty			CSDS/DMHA, 2002
Number of children estimated to be eligible for waiver services	2,200		Applying Kansas waiver prevalence

- The Kansas experience and projection rates can be applied to project the statewide number of youth who might be eligible for services under the waiver in Indiana. Two pilot sites of a federally funded project in Kansas indicated that approximately 2.25% of all children were in service and identified as having a severe emotional disturbance. Of the 2.25% (9,985) children with SED in Kansas in service, 10% of the children would meet clinical eligibility requirements for the waiver. Using the 1995 data, Kansas projected that between 1000 and 1700 children would present for waiver services. In 2003, 1300 children are being served in Kansas without a waiting list. Applying these estimated rates to Indiana's 2000 population would project a statewide eligibility of 2,200 children; however,

- the model waiver will serve 50 children in the first year and up to 200 in the second and third years, depending upon availability of match. Statewide eligibility projections will be refined based on the experience of the pilot. The model waiver will be piloted in five to 10 communities.

APPENDIX G-2
METHODOLOGY FOR DERIVATION OF FORMULA VALUES

FACTOR D

LOC: Inpatient State hospital Care

The July 25, 1994 final regulation defines Factor D as:

> "The estimated annual average per capita Medicaid cost for home and community-based services for individuals in the waiver program."

The demonstration of Factor D estimates is on the following page.

INDIANA
APPENDIX G-2
FACTOR D
SED Waiver
Demonstration of factor D estimates
Waiver Year: 1
Year 2004

A	B	C		D	E
Waiver Service	# Unduplicated Recipients Using Service	Average Annual Units Per User		Average Cost Per Unit	Total
Independent Living Skills	33	90	hour	$ 85.60	$ 254,232
Family Support and Training	33	32	hour	$ 60.00	$ 63,360
Respite - Hour	20	239	hour	$ 16.00	$ 76,480
Respite - Foster	10	11	day	$ 100.00	$ 11,000
Respite - Crisis	15	11	day	$ 120.00	$ 19,800
Respite - Scheduled Day	10	11	day	$ 80.00	$ 8,800
Wraparound Facilitation	50	36	hour	$ 115.00	$ 207,000
GRAND TOTAL					$ 640,672
FACTOR C					50
FACTOR D					$ 12,813
AVERAGE LENGTH OF STAY					221

INDIANA
APPENDIX G-2
FACTOR D
SED Waiver
Demonstration of factor D estimates
Waiver Year: 2
Year 2005

A	B	C		D	E
Waiver Service	# Unduplicated Recipients Using Service	Average Annual Units Per User		Average Cost Per Unit	Total
Independent Living Skills	132	90	hour	$ 85.60	1,016,928
Family Support and Training	132	32	hour	$ 60.00	253,440
Respite - Hour	80	239	hour	$ 16.00	305,920
Respite - Foster	40	11	day	$ 100.00	44,000
Respite - Crisis	60	11	day	$ 120.00	79,200
Respite - Scheduled Day	40	11	day	$ 80.00	35,200
Wraparound Facilitation	200	36	hour	$ 115.00	828,000
GRAND TOTAL					2,562,688
FACTOR C					200
FACTOR D					$ 12,813
AVERAGE LENGTH OF STAY					221

INDIANA
APPENDIX G-2
FACTOR D
SED Waiver
Demonstration of factor D estimates
Waiver **3**
Year **2006**

A	B	C		D	E
Waiver Service	# Unduplicated Recipients Using Service	Average Annual Units Per User		Average Cost Per Unit	Total
Independent Living Skills	132	92	hour	$ 85.60	1,039,526
Family Support and Training	132	33	hour	$ 60.00	261,360
Respite - Hour	80	243	hour	$ 16.00	311,040
Respite - Foster	40	11	day	$ 100.00	44,000
Respite - Crisis	60	11	day	$ 120.00	79,200
Respite - Scheduled Day	40	11	day	$ 80.00	35,200
Wraparound Facilitation	200	37	hour	$ 115.00	851,000
GRAND TOTAL					$ 2,621,326
FACTOR C					200
FACTOR D					$ 13,107
AVERAGE LENGTH OF STAY					225

First Year-Computation of Factor D

The estimated annual per capita Medicaid cost for home and community-based services for individuals in the first year of the waiver program.

Data Sources:

1. The utilization of services related to the waiver program was obtained from the experience of a federally funded system of care, the Dawn Project, Marion County, Indiana, n = 524.

Indiana has two federally funded systems of care whose objective is to ensure that enrolled youth have access to the most comprehensive and clinically appropriate array of services possible. The Dawn Project, which began in 1997, had served 691 youth as of February, 2003. A service utilization study (Wright & Korreman, 2003) analyzed the service and cost records of all children who have been discharged from Dawn as of March 30,2003. The general patterns of service and associated costs of care were evaluated. Six service utilization patterns were found in a cluster analysis, ordered from least to most intensive. Most youth received a comprehensive array of services with most youth referred while in out-of-home placement. Costs ranged from $4,467 average cost to $65,450 per child. Youth in Patterns 4 and 5 were similar demographically and clinically with some youth referred by LaRue State Hospital for transition to the community. The biggest difference in Levels 4/5 and 6 is the provision of residential services.

Table 1. Average Costs of Service Use Patterns
(Wright & Kooreman, 2003)

	Behavioral Health Services	Discretionary Funds	Mentor Services	Placement Services	Respite Services	Supervision Services	Pattern Average Total Cost	Pattern Standard Deviation
Pattern 1	$2342	$1047	$0	$$0	$1052	$26	$4467	$6122
Pattern 2	$0	$790	$516	$17131	$247	$18	$18702	$30525
Pattern 3	$2850	$2332	$8060	$21018	$3623	$0	$37883	$36492
Pattern 4	$2595	$1442	$6565	$24071	$0	$0	$34673	$26452
Pattern 5	$2978	$2360	$0	$22462	$5326	$1662	$34788	$31137
Pattern 6	$5096	$3299	$9142	$43093	$2528	$2292	$65450	$52227

Services that made up the various patterns represent clusters of services as described in Table 2. The table provides a description of the types of services and the number of youth (and percentage) that received services in each category. As 100% of the Dawn youth received some form of service coordination, this category of service was excluded from the cluster analysis that identified the patterns.

Table 2. Examples of Services in Collapsed Service Categories (Wright & Kooreman, 2003)

Collapsed Service Category	Services in the Category	N	%
Behavioral Health Services	**Behavior Management Services, Crisis Intervention, Day Treatment, Family Assessment, Family Therapy, Group Therapy**	**375**	**71.8%**
Discretionary Funds	**Activities, Automobile, Camp, Clothing, Housing, Incentive Money**	**515**	**98.5%**
Mentor Services	**Case Aide, Case Management, Clinical Mentor, Educational Mentor, Parent & Family Mentor**	**339**	**64.7%**
Placement Services	**Acute Psychiatric Hospitalization, Foster Care, Group Home Care, Relative Placement, Residential Treatment**	**354**	**67.6%**
Respite	**Crisis Respite, Planned Respite**		
Supervision Services	**Community Supervision, Intensive Supervision, OFC Supervision, Parole Supervision**	**217**	**41.4%**
Service Coordination	**Case Management (internal), Service Coordination, Team Meeting**	**255**	**48.7%**
		524	**100%**

Limitations: The data are based on charges paid to Choices (Dawn) and estimated charges for services authorized but paid for by other sources (e.g. Medicaid). It is possible that not all of the authorized services were utilized and paid. These are preliminary, unadjusted aggregate estimates. Not taken into account are individual variations in clinical need, service disposition, demographic information, or outcomes.

The percentages of service utilization from Wright & Kooreman's (2003) study of the Dawn Project were used to project the anticipated rate of utilization of HCBS/SED Waiver services and the total anticipated average Medicaid expense per child. The waiver services compare with the Dawn services as follows:

HCBS/SED Waiver Services	Dawn Project Service Clusters
Independent Living/Skill Building	Mentor Services
Parent Support and Training	Mentor Services
Respite	Respite
Wraparound Facilitation	Service Coordination

Information regarding the usual/customary rates for supportive services such as mentoring and respite services now purchased by federally funded systems of care (Dawn and Circle Around Families) was used to inform the rates of waiver services.

2. Indiana's State Medicaid Plan determined maximum fees for Medicaid Rehabilitation Option Services, some of which are similar to the Medicaid waiver services.

MEDICAID REHABILITATION OPTION SERVICES		
Max Fees		
Procedure Code	**Pricing Effective Date**	**Fee Schedule Amount**
X3048 - Training in ADL	10/06/1994	$21.40
X3050 - Case Management Services	10/06/1994	$26.14
1 unit = 15 minutes		
This information can be found on www.indianamedicaid.com (on "site favorites"		

3. Information from IARCCA regarding rates for respite, life skill training, and support services for families.
4. Information from Division of Family and Children on rates.

Match Pool. To provide the necessary matching dollars for the HCBS/SED waiver, a pool of state funds has been braided from multiple state agencies that serve troubled youth—Department of Correction (DOC), Department of Education, Division of Exceptional Learners (DOE), and Family and Social Services Administration (FSSA), Division of Mental Health and Addiction (DMHA). MOUs are being developed between agencies partnering to enhance and support intensive community based alternatives to hospital care. A dedicated account has been established in FSSA to hold the funds from DMHA and DOC. The match from DOE will be reconciled and paid quarterly. As of May 22, 2003, DMHA has pre-obligated $760,000 for match for SFY2004; DOC has pledged $300,000 for the three year model waiver; and DOE is willing to provide match when an eligible child also fits special education's criteria for intensive community based supports to make possible local education of a EH child. FSSA's Division of Family and Children (child welfare) is also working closely with the expansion of community based services; match for the waiver may be provided in the future as resources are available.

Computation of Factor D
Analysis and Calculations

- A cross walk of Dawn Project services to waiver services was completed (see description above). The utilization of waiver services was projected using the Dawn Project as a "pilot" for the waiver, a federally funded system of care that serves many children who would meet the level of care criteria for the waiver. In operation for about six years, the federally funded system of care has served about 691 youth in Marion County, Indiana. The experience of this service delivery system is a well-developed intensive community based service delivery system that provides services similar to the waiver and serves a similar population.

- Average annual units for each waiver services were calculated by multiplying the total number of waiver participants for each year time the percentage expected to participate in each waiver service, based on the utilization patterns of Dawn consumers for similar services (Wright & Kooreman, 2003).

- Some rates were based on the current rate for the same service provided by other Indiana Waivers, e.g. the hourly Respite rate is $16/hour for the Indiana Autism waiver.

- **Rate Setting**:

    - The **Respite** hourly rate was based on the rate set by other Indiana Medicaid waivers, $16/hour.
    - The **Respite daily therapeutic foster care** rate was based on the prevailing daily rate for therapeutic foster homes used as respite for other homes ($50 to $90/day). As the HCBS/SED waiver children are assumed to have greater needs than children routinely in therapeutic foster care, the respite rate was set higher, at $100/day. (Level IV therapeutic foster homes have negotiated rates dependent upon the child's needs, as high as $225-$260/day for a developmentally disabled child.) (IARCCA, 2003).
    - The **Respite daily Crisis rate** was based on the current rate for respite in a licensed crisis shelters, ranging $90 to $150/day depending upon the child's needs (IARCCA, 2003). As the HCBS/SED children are assumed to have a high level of need, the rate was set at the mean, $120/day.
    - The **Respite daily Routine rate** was based on the current rate for respite in a group setting at $80/day (Gilbault, 2003).

The rate for **Wraparound Facilitation**, an intensive form of case management used to manage the waiver plan and facilitate the child-family team wraparound process, was based on an enhanced MRO case management rate, at $115 hour versus $104.56 for case management. Wraparound facilitators will manage the child-family team meetings that include all individuals and service providers (child and family, child welfare, special education, probation, waiver providers, support system). A strength based assessment identifies abilities and needs. Services are allocated and resources identified to meet identified needs.

The rate for Independent Living/Skill Building was based on the MRO Training in ADL rate of $21.40/15 minutes or $85.60/hour. MRO services are available only through the CMHCs; the waiver opens the door to other potential providers to build community capacity for intensive community based services.

The average unit costs are as follows:

- Independent Living/Skill Development $85.60/hour
- Parent Support and Training $60/hour
- Respite, $16/hour; $ 100/day in foster care; $120/day crisis shelter; $80 day scheduled respite greater than or equal to 5 hours/day.
- Wraparound Facilitation ($115/hour)

- Although Factor C explores the expected statewide prevalence, the model waiver will be a pilot that will serve no more than 50 children and no more than 200 children at any one time in the second and third years.
- The number of unduplicated recipients (users) for each waiver service was based on the total number of unduplicated recipients multiplied by the ratio of Dawn recipients who received the service to the total number of Dawn recipients.

- The average number of annual units for the wavier was calculated by multiplying the average number of units per person in the pilot (DAWN) by 61% (the projected length of stay for the first and second years of the waiver (221 days)).

- The total costs for each service was obtained by multiplying the number of unduplicated recipients for each service by the average annual units and average unit cost for each waiver service.

- A sum of the cost for each waiver service was obtained and divided by the total number of unduplicated recipients to obtain Factor D.

APPENDIX G-3
METHODS USED TO EXCLUDE PAYMENTS FOR ROOM AND BOARD

The purpose of this Appendix is to demonstrate that Medicaid does not pay the cost of room and board furnished to an individual under the waiver.

A. The following service(s), other than respite care*, are furnished in residential settings other than the natural home of the individual (e.g., foster homes, group homes, supervised living arrangements, assisted living facilities, personal care homes, or other types of congregate living arrangements). (Specify):

None

*NOTE: FFP may be claimed for the cost of room and board when provided as part of respite care in a Medicaid certified NF or ICF/MR, or when it is provided in a foster home or community residential facility that meets State standards specified in this waiver.)

B. The following service(s) are furnished in the home of a paid caregiver. (Specify):

None

Attached **below** is an explanation of the method used by the State to exclude Medicaid payment for room and board.

Method used to exclude room and board payments:

None

APPENDIX G-4
METHODS USED TO MAKE PAYMENT FOR RENT AND FOOD EXPENSES OF AN UNRELATED LIVE-IN CAREGIVER

Check one:

__x__ The State will not reimburse for the rent and food expenses of an unrelated live-in personal caregiver who lives with the individual(s) served on the waiver.

____ The State will reimburse for the additional costs of rent and food attributable to an unrelated live-in personal caregiver who lives in the home or residence of the individual served on the waiver. The service cost of the live-in personal caregiver and the costs attributable to rent and food are reflected separately in the computation of factor D (cost of waiver services) in Appendix G-2 of this waiver request.

Attached **below** is an explanation of the method used by the State to apportion the additional costs of rent and food attributable to the unrelated live-in personal caregiver

APPENDIX G-5
FACTOR D'

LOC Inpatient State Hospital Care

NOTICE: On July 25, 1994, HCFA published regulations, which changed the definition of factor D'. The new definition is:

> "The estimated annual average per capita Medicaid cost for all other services provided to individuals in the waiver program."

Include in Factor D' the following:

> The cost of all State plan services (including home health, personal care and adult day health care) furnished in addition to waiver services WHILE THE INDIVIDUAL WAS ON THE WAIVER.
>
> The cost of short-term hospitalization, which began AFTER the person's first day of waiver, services and ended BEFORE the end of the waiver year IF the person returned to the waiver.

Do NOT include the following in the calculation of Factor D':

> If the person did NOT return to the waiver following hospitalization, do NOT include the costs of hospital care.
>
> Do NOT include hospital costs incurred BEFORE the person is first served under the waiver in this waiver year.

If institutional respite care is provided as a service under this waiver, calculate its costs under Factor D. Do not duplicate these costs in your calculation of Factor D'.

Factor D' is computed as follows (check one):

____ Based on HCFA Form 2082 (relevant pages attached).
____ Based on HCFA Form 372 for years ___ of waiver # _, which serves a similar target population. Factor D is inflated forward by % per year for two years (FY and .
____ Based on a statistically valid sample of plans of care for individuals with the disease or condition specified in item 3 of this request.

___x_ Other (specify): See Attachment to Appendix G-5.

Other anticipated Medicaid expenses were estimated from the experience of the Dawn Project and other states with Home and Community Based Service Waivers.

APPENDIX G-6
FACTOR G

LOC: Inpatient State Hospital Care

The July 25, 1994 final regulation defines Factor G as:

> "The estimated annual average per capita Medicaid cost for hospital, NF, or ICF/MR care that would be incurred for individuals served in the waiver, were the waiver not granted."

Provide data ONLY for the level(s) of care indicated in item 2 of this waiver request.

Factor G is computed as follows:

____ Based on hospital cost trends shown by HCFA Form 2082 (relevant pages attached). Attached is an explanation of any adjustments made to these numbers.

__ Based on trends shown by HCFA Form 372 for years of waiver #_____which reflect costs for a hospitalized population at this LOC.

Below is an explanation of any adjustments made to these numbers:

____ Based on actual case histories of individuals hospitalized with this disease or condition at this LOC. Documentation attached.

____ Based on State DRGs for the disease(s) or condition(s) indicated in item 3 of this request, plus outlier days. Descriptions, computations, and an explanation of any adjustments are attached to this Appendix.

__x__ Other (specify): See Attachment to Appendix G-6.

APPENDIX G-7
FACTOR G'

LOC: Inpatient State Hospital Care

The July 25, 1994 final regulation defines Factor G' as:

> "The estimated annual average per capita Medicaid costs for all services other than those included in Factor G for individuals served in the waiver, were the waiver not granted.

Include in Factor G' the following:

> The cost of all State plan services furnished WHILE THE INDIVIDUAL WAS HOSPITALIZED.
>
> The cost of short-term hospitalization (furnished with the expectation that the person would return to the hospital) which began AFTER the person's first day of hospital services.

If institutional respite care is provided as a service under this waiver, calculate its costs under Factor D. Do not duplicate these costs in your calculation of Factor G'.

Factor G' is computed as follows (check one):

____ Based on HCFA Form 2082 (relevant pages attached).

_____ Based on HCFA Form 372 for years _____ of waiver # _____, which serves a similar target population. The costs of Medicaid card services are increased by % per year for two years to reflect anticipated increases in the costs of these services.

____ Based on a statistically valid sample of plans of care for individuals with the disease or condition specified in item 3 of this request.

_x_ Other (specify): See Attachment to Appendix G-7.

APPENDIX G-8
DEMONSTRATION OF COST NEUTRALITY

LOC: Inpatient State Hospital Care

YEAR 1

FACTOR D:	$12,813		FACTOR G:	$54,513
FACTOR D':	$ 9,061		FACTOR G':	$ 2,007
TOTAL:	$21,874	≤	TOTAL:	$56,520

YEAR 2

FACTOR D:	$12,813		FACTOR G:	$54,513
FACTOR D':	$ 9,786		FACTOR G':	$ 2,167
TOTAL:	$22,599	≤	TOTAL:	$ 56,680

YEAR 3

FACTOR D:	$13,107		FACTOR G:	$55,603
FACTOR D':	$10,569		FACTOR G':	$ 2,341
TOTAL:	$23,676	≤	TOTAL:	$57,994

Attachment to Appendix G-5

Computation of Factor D'

First Year – Computation of Factor D'

The estimated annual average per capita Medicaid cost for all other services provided to individuals in the first year of the waiver program.

Data Source.

The utilization and expenditures for other services provided to individuals in the waiver program was obtained from data from the Dawn Project, a federally funded system of care site in Marion County, Indiana, in operation for about six years, and serving a similar population through a comprehensive system of care. A73% sample (N= 504) of the children served by the Dawn project with a service date July 1,2001 through June 30, 2002 was obtained. This information was matched to the Medicaid Management Information System to obtain expenditures and utilization for Medicaid services that the Dawn participants received.

Analysis and Calculations (See Exhibit 1)

- Recipient data from the Dawn project was matched with OMPP data to obtain the units of other Medicaid services and the number of Dawn recipients who used other Medicaid services.
- Other categories of service utilized by recipients were identified as follow:

Inpatient Services (61)	Non-Physician Practitioner (104)
Inpatient Psychiatric Private (18)	Physician Medical Clinic (220)
Outpatient Emergency (41)	Legend Drugs (301)
Outpatient Non-Emergency (65)	OTC Drugs (72)
Outpatient Non-Emergency Room (217)	DME Supplies (22)
Capitated Services - Risk Based Premiums (253)	Transportation Services (50)
Other Services (190)	Home Health & Related Services (1)
Physician PCCM Administrative Fee)(95)	Mental Health Rehab Services (385)
Physician General Practitioner (62)	Other Mental Health Services (338)
Physician Family Practitioner (75)	Dental Services (251)
Physician General Pediatrics (47)	Chiropractic Services (1)
Physician OB/GYN (17)	Podiatrist Services (5)
Physician General Internist (27)	Optometric & Optician Services (101)
Physician Specialist (132)	

- For each category of service, the number of recipients receiving that category of service was identified from the MMIS data.

Attachment to Appendix G-5
Computation of Factor D'

- Total expenditures for each category of service were identified from the MMIS data.
- For each category of service, the average per capita cost was obtained by dividing the expenditures for that category of service by the number of Dawn recipients receiving that category of service.
- The percentage of recipients each category of service was calculated by dividing the number of pilot recipients who received each service by the total number of recipients.
- The projected number of waiver recipients receiving other services was calculated by multiplying the total number of unduplicated recipients (50) by the percentage of pilot recipients receiving each category of service.
- The project expenditures for each category of service were calculated by multiplying the average per capita expenditure by the projected number of waiver recipients to receive the service.
- The projected expenditures for each category of services were summed and then divided by the total number of unduplicated recipients in Year 1 (50) to obtain an overall per capita expenditure number.
- The average number of annual units for non-waiver Medicaid services was calculated by multiplying the Projected Expenditures for Other Medicaid Services by 61%, the projected length of stay for children served on the waiver (221/366).
- The resulting Total Per Capita Expenditure of $8,390.14 was multiplied by 1.08 to adjust for inflation between SFY2002 and SFY2005. (($9061)

Year 2
$9061 x 1.08 = $9,786 (to adjust for inflation)

Year 3
$9786 x 1.08 = $10,569 (to adjust for inflation)
Note: since the length of stay is close to year 1 and 2, there is no need to make any further adjustment.

Exhibit 1

D Prime Factor – Year 1
Annual Average Per Capita Medicaid Costs for All Other Services Provided To Individuals in the HCBS/SED Waiver

Other Medical Services	Number of Pilot Recipients Receiving Other Services A	Expenditures For Other Services Provided to Pilot Recipients B	Average Per Capita C=(B/A)	Pilot Recipients Receiving Other Services as % of All Pilot Recipients D=(A/504)	Projected Number of Waiver Recipients Receiving Other Services E=(D*50)	Projected Expenditures for Other Medicaid Services F=(C*E*.61)
Inpatient Services	61	556,781.43	9,127.56	12%	6	$33,406.89
Inpatient Psychiatric Private	18	123,712.58	6,872.92	4%	2	$8,384.96
Outpatient Emergency	41	6,131.37	149.55	8%	4	$364.89
Outpatient Non-Emergency	65	7,780.35	119.70	13%	7	$511.11
Outpatient Non-Emergency Room	217	54,179.34	249.67	43%	22	$3,350.63
Capitated Services - Risk Based Premiums	253	151,464.99	598.68	50%	25	$9,129.81
Other Services	190	43,455.80	228.71	38%	19	$2,650.80
Physician PCCM Administrative Fee	95	2,872.68	30.24	19%	10	$184.46
Physician General Practitioner	62	4,114.29	66.36	12%	6	$242.88
Physician Family Practitioner	75	6,078.54	81.05	15%	8	$395.51
Physician General Pediatrics	47	3,606.43	76.73	9%	5	$234.03
Physician OB/GYN	17	3,904.52	229.68	3%	2	$280.21
Physician General Internist	27	784.00	29.04	5%	3	$53.14
Physician Specialist	132	22,523.25	170.63	26%	13	$1,353.10
Non-Physician Practitioner	50	5,371.46	107.43	10%	5	$327.66
Physician Medical Clinic	76	9,543.91	125.58	15%	8	$612.82
Legend Drugs	301	556,347.39	1,848.33	60%	30	$33,824.44

OTC Drugs	72	1,774.44	24.65	14%	7	$105.23
DME Supplies	22	18,496.28	840.74	4%	2	$1,025.70
Transportation	50	16,778.01	335.56	10%	5	$1,023.46
Home Health & Related Services	1	60.50	60.50	.2%	1	$36.91
Mental Health Rehab Services	385	3,626,904.73	9,420.53	76%	50*	$287,326.22
Other Mental Health Services	338	295,780.58	875.09	67%	50**	$26,690.26
Dental Services	251	115,134.23	458.70	50%	25	$6,995.21
Chiropractic Services	1	298.08	298.08	.2%	1	$181.83
Podiatrist Services	5	264.26	52.85	1%	1	$32.24
Optometric & Optician Services	101	12,960.95	128.33	20%	10	$782.79

Total Expenditures	$419,507.18
Divided by Number of Waiver Recipients	50
Total Per Capita Expenditure	$ 8390.14
Adjusted Total Per Capita Expenditure***	$9,061

Source of data- Dawn pilot data was matched to MMIS for all paid claims and recipients who had a date of service during July 1, 2001-June 30, 2002. Data includes Medicaid eligible children and youth under 22 enrolled in the pilot who received other Medicaid services. An individual could have received more than one service.

Notes:
*(E) Projected Number of Waiver Recipients Receiving Mental Health Rehabilitation Option Services adjusted from 38 (based on pilot) to 50 given design of waiver to merge Waiver and state Medicaid plan.
**(E) Projected Number of Waiver Recipients Receiving Other Mental Health Services adjusted from 34 (based on pilot) to 50 given design of waiver to merge Waiver and state Medicaid plan. (Pilot has also has blended capitated funding to purchase services.)
*** The Total Per Capita Expenditure of $8,390.14 was multiplied by 1.08 to adjust for inflation between SFY2002 and SFY2005.

Attachment to Appendix G-6
Computation of Factor G

The methods used to obtain and calculate Factor G for each year of the waiver is described below.

Computation of Factor G

The estimated annual per capita Medicaid cost for hospital care that would be incurred for individuals served in the first year of the waiver, were the waiver not granted.

Data Source:

1. The number of recipients served in the absence of the waiver and expenditures for services were obtained from the Medicaid Management Information System (MMIS) data from July 1, 2001 through June 30, 2002. This data identified 300 individual recipients under the age of 22 who had at least one date of service in an inpatient state mental health hospital with a diagnosis of serious emotional disturbance.

Analysis and Calculations (See Exhibit 4.)

Year 1

- The total number of unique beneficiaries identified with a category of service of inpatient state mental health care for dates of service July 1, 2003 through June 30, 2003 was three hundred (300).
- The average length of stay for children discharged from an Indiana state hospital is 8 months. (See Exhibit 5.)
- Paid inpatient psychiatric state hospital claims for the three hundred children was calculated to be $16,135,818.15.*
- The average per capita Medicaid cost for inpatient psychiatric state hospital care was determined by dividing the total expenditures ($16,135,818.15) by the number of unduplicated recipients (300).*
- The average per capita cost for hospital care was $54,512.90 for the first year for individuals served in the waiver (were the waiver not granted).
- No appreciable change in state hospital cost from SFY2002 to SFY2004 is expected. The SFY2003 final costs are not yet available. (per Dale Marion, Deputy Director for Client Services (state hospitals), June 17, 2003).

Year 2:

- Given the state budgetary crisis, the state hospital budgets have been flat lined for SFY 2004 and SFY2005 (Marion, 2003). Therefore, no increase is anticipated in expenditures from the first to second year of the waiver.

- Given the relatively small size of the first year waiver, N= 50, minimal impact is anticipated regarding the length of stay for children in state hospitals. The length of stay is expected to remain the same, 8 months.

- Therefore, the state hospital cost for children is expected to remain the same for SFY2005, $54,512.90.

Year 3

- Although the state hospital budgets have been flat lined for SFY 2004 and SFY2005, a factor of 2% was used to calculate the increase in expense for SFY2006, the third year of the waiver. The anticipated expenditure for third year for recipients served in a hospital is $55,603.16; this is the sum of the second year average per capita expenditures plus the estimate of the increase in expenditures from the second to the third year ($54,512.90 + $1090.26).

- The number of unduplicated individuals being served in a hospital for the third year is expected to remain the same as the number of individuals served in the first and second years.

- This calculation assumes that the length of stay remains the same, 8 months.

Source data from Indiana MMIS

Exhibit 2 Medicaid Beneficiaries under the age of 22 in a State Mental Health Hospital – SFY2002

Source: Indiana MMIS

Category of service	Paid claims	Amount Paid	Unique recipients of service N = 300	Cost per recipient per service
Inpatient Services	32	$ 8,324.45	2	$ 4,162.23
Inpatient Psychiatric State	2,787	$16,135,818.15	296	$ 54,512.90
Inpatient Psychiatric Private	1	$ 4,228.35	1	$ 4,228.35
Outpatient Emergency	25	$ 2,324.33	21	$ 110.68
Outpatient Non-Emergency	14	$ 962.51	10	$ 96.25
Outpatient Non-Emergency Room	776	$ 32,394.39	103	$ 314.51
Capitated Services - Risk Based Premiums	31	$ 2,382.12	13	$ 183.24
Other Services	916	$ 17,777.24	96	$ 185.18
Physician PCCM Administrative Fee	250	$ 750.00	70	$ 10.71
Physician Family Practitioner	7	$ 162.55	2	$ 81.28
Physician General Pediatrics	2	$ 96.12	2	$ 48.06
Physician OB/GYN	4	$ 149.21	2	$ 74.61
Physician General Internist	74	$ 2,182.53	34	$ 64.19
Physician Specialist	138	$ 7,720.44	49	$ 157.56
Non-Physician Practitioner	6	$ 258.20	4	$ 64.55
Physician Medical Clinic	71	$ 5,717.22	45	$ 127.05
Legend Drugs	372	$ 23,118.31	48	$ 481.63
OTC Drugs	7	$ 25.28	4	$ 6.32
DME Supplies	6	$ 290.09	4	$ 72.52
Transportation Services	74	$ 4,733.37	18	$ 262.97
ICF-MR State	34	$ 314,350.20	5	$ 62,870.04
Mental Health Rehab Services	1,257	$ 90,848.85	82	$ 1,107.91
Other Mental Health Services	133	$ 13,872.58	53	$ 261.75
Dental Services	523	$ 20,216.22	63	$ 320.89
Chiropractic Services	10	$ 142.13	1	$ 142.13
Podiatrist Services	16	$ 695.01	5	$ 139.00
Optometric & Optician Services	114	$ 3,675.98	38	$ 96.74
Total Costs	7,680	$16,693,215.83	300	$ 55,644.05

Exhibit 3 Length of Stay for Children with SED in State Hospitals SFY 2002
Source: (Indiana DMHA Data Base)

								LOS		
Age Range	**FY DISCHARGE**	**Age @ FY End**	**Served**	**Admits**	**Discharges**	**LOS Days**	**LOT Days**	**Enrolled @ FY End**	**Discharged Patients**	**All Served**
05-08	N	7	2	2	0	0	324	**173**	**207**	**195**
05-08	N	8	4	4	0	0	716			
05-08	Y	8	11	7	11	2281	2281			
09-13	N	9	11	11	0	0	932	**116**	**201**	**169**
09-13	N	10	4	4	0	0	471			
09-13	N	11	6	6	0	0	712			
09-13	N	12	8	8	0	0	742			
09-13	N	13	11	11	0	0	1763			
09-13	Y	9	7	3	7	1526	1526			
09-13	Y	10	15	7	15	2832	2832			
09-13	Y	11	10	7	10	1866	1866			
09-13	Y	12	14	5	14	3080	3080			
09-13	Y	13	19	7	19	3784	3784			
14-17	N	14	8	8	0	0	780	**292**	**305**	**298**
14-17	N	15	14	12	0	0	3043			
14-17	N	16	14	5	0	0	5988			
14-17	N	17	17	12	0	0	5677			
14-17	Y	14	10	4	10	2275	2275			
14-17	Y	15	6	2	6	1790	1790			
14-17	Y	16	21	9	21	6897	6897			
14-17	Y	17	11	3	11	3682	3682			
		13	**223**	**137**	**124**	**30,013**	**51,161**	**214**	**242**	**229**
		Wt. Avg.	Tot	Tot	Tot	Tot	Tot	Avg	Avg	Avg

Length of Stay for Children Discharged from State Operated Facilities (SOF) was 242 days or 8 months.

Attachment to Appendix G-7
Computation of Factor G'

First Year – Computation of Factor G'

The estimated annual average per capita Medicaid cost for all services other than those included in Factor G for individuals served in the waiver, were the waiver not granted for the first year of the waiver.

Data source:

The number of recipients served in the absence of the waiver and expenditures for services were obtained from the Medicaid Management Information System (MMIS) data from July 1, 2001 through June 30, 2002. This data identified 300 individual recipients under the age of 22 who had at least one date of service in an inpatient state mental health hospital with a diagnosis of serious emotional disturbance.

Analysis and Calculations

- The estimated annual average per capita Medicaid costs for all services other than those included in Factor G were calculated by adding up all of the Non-Inpatient Psychiatric State Hospital paid claims for children and youth that were served in a state hospital in SFY 2002 and then dividing the total number of children (300). See Exhibit 4.

- The number of unduplicated individuals being served for all other Medicaid services while in a hospital is 300.

- The number ($1,857.99) serves as an estimate of expenditures for recipients using other services who are being served by an inpatient state hospital.

Attachment to Appendix G-7
Computation of Factor G'

Second Year – Computation of Factor G'

The estimated annual average per capita Medicaid cost for all services other than those included in Factor G for individuals served in the waiver, were the waiver not granted for the second year of the waiver.

Data source:

The number of recipients served in the absence of the waiver and expenditures for services were obtained from the Medicaid Management Information System (MMIS) data from July 1, 2001 through June 30, 2002. This data identified 300 individual recipients under the age of 22 who had at least one date of service in an inpatient state mental health hospital with a diagnosis of serious emotional disturbance.

Analysis and Calculations

- The estimated annual average per capita Medicaid costs for all services other than those included in Factor G were calculated based on the cost of non hospital Medicaid. See Exhibit 4.
- A factor of 8% was used to project the expected rate of growth on non-hospital Medicaid costs.
- The first year costs were multiplied by 8%; 8% was added to the first year costs. The total serve costs were added, then divided by the number of unduplicated individuals that are estimated to be served.
- The number of unduplicated individuals being served for all other Medicaid services while in a hospital remains 300.
- The number ($2006.63) serves as an estimate of expenditures for recipients using other services who are being served by an inpatient state hospital during the second year.

Attachment to Appendix G-7
Computation of Factor G'

Third Year – Computation of Factor G'

The estimated annual average per capita Medicaid cost for all services other than those included in Factor G for individuals served in the waiver, were the waiver not granted for the third year of the waiver.

Data source:

The number of recipients served in the absence of the waiver and expenditures for services were obtained from the Medicaid Management Information System (MMIS) data from July 1, 2001 through June 30, 2002. This data identified 300 individual recipients under the age of 22 who had at least one date of service in an inpatient state mental health hospital with a diagnosis of serious emotional disturbance.

Analysis and Calculations

- The estimated annual average per capita Medicaid costs for all services other than those included in Factor G were calculated based on the Second Year cost of non hospital Medicaid. See Exhibit 4.
- A factor of 8% was used to project the expected rate of growth on non-hospital Medicaid costs.
- The second year costs were multiplied by 8%; 8% was added to the second year costs. The total serve costs were added, then divided by the number of unduplicated individuals that are estimated to be served.
- The number of unduplicated individuals being served for all other Medicaid services while in a hospital is 300.
- The number ($2167.16) serves as an estimate of expenditures for recipients using other services who are being served by an inpatient state hospital during the third year.

Exhibit 6 Non Institutional Medicaid Costs for Children Served in a State Hospital (G')
Source: MMIS for claims paid for children with SED in SOF in SFY 2002

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Category of service	Paid claims	Amount Paid	Unique recipients of service	Cost per recipient per service	8% increase	2nd year8% increase	8% increase	3rd year 8 % increase
Inpatient Services	32	$ 8,324.45	2	$ 4,162.23	332.97	4495.20	359.61	4854.81
Inpatient Psychiatric Private	1	$ 4,228.35	1	$ 4,228.35	338.26	4566.62	365.32	4931.94
Outpatient Emergency	25	$ 2,324.33	21	$ 110.68	8.85	119.54	9.56	129.09
Outpatient Non-Emergency	14	$ 962.51	10	$ 96.25	7.70	103.951	8.31	112.26
Outpatient Non-Emergency Room	776	$ 32,394.39	103	$ 314.51	25.16	339.67	27.17	366.84
Capitated Services - Risk Based Premiums	31	$ 2,382.12	13	$ 183.24	14.65	197.90	15.83	213.73
Other Services	916	$ 17,777.24	96	$ 185.18	14.81	199.99	15.99	215.99
Physician PCCM Administrative Fee	250	$ 750.00	70	$ 10.71	0.85	11.5714	0.92	12.49
Physician Family Practitioner	7	$ 162.55	2	$ 81.28	6.50	87.78	7.02	94.79
Physician General Pediatrics	2	$ 96.12	2	$ 48.06	3.84	51.905	4.15	56.05
Physician OB/GYN	4	$ 149.21	2	$ 74.61	5.96	80.57	6.44	87.01
Physician General Internist	74	$ 2,182.53	34	$ 64.19	5.13	69.32	5.54	74.87
Physician Specialist	138	$ 7,720.44	49	$ 157.56	12.60	170.16	13.61	183.77
Non-Physician Practitioner	6	$ 258.20	4	$ 64.55	5.16	69.71	5.57	75.29
Physician Medical Clinic	71	$ 5,717.22	45	$ 127.05	10.16	137.21	10.97	148.19
Legend Drugs	372	$ 23,118.31	48	$ 481.63	38.53	520.16	41.61	561.77
OTC Drugs	7	$ 25.28	4	$ 6.32	0.50	6.83	0.54	7.37
DME Supplies	6	$ 290.09	4	$ 72.52	5.80	78.32	6.26	84.59
Transportation Services	74	$ 4,733.37	18	$ 262.97	21.03	284.00	22.72	306.72
ICF-MR State	34	$ 314,350.20	5	$ 62,870.04	5029.60	67899.64	5431.97	73331.61
Mental Health Rehab Services	1,257	$ 90,848.85	82	$ 1,107.91	88.63	1196.55	95.72	1292.26
Other Mental Health Services	133	$ 13,872.58	53	$ 261.75	20.94	282.69	22.61	305.30
Dental Services	523	$ 20,216.22	63	$ 320.89	25.67	346.56	27.72	374.28
Chiropractic Services	10	$ 142.13	1	$ 142.13	11.37	153.50	12.28	165.78
Podiatrist Services	16	$ 695.01	5	$ 139.00	11.12	150.12	12.01	162.13
Optometric & Optician Services	114	$ 3,675.98	38	$ 96.74	7.74	104.48	8.35	112.83
	7,680	$ 557,397.68	300	$ 1,857.99	148.64	2006.63	160.53	2167.16